

The Ombudsman's Casebook

Issue 27 January 2017

News

Out of Hours: Time to Care

Earlier this year the Ombudsman published his first thematic report on the poor quality of out of hours care in Welsh hospitals. In the report he called on the government to conduct a review of what we believe is a systemic issue.

Despite the initial backlash he is delighted that the government has recently announced that the report is one of the catalysts for a peer review it will be conducting in 2017 into care of acutely ill patients. We will publish updates on the review over the course of the year.



Out of hours: Time to care



Health Sounding Board

Following the success of the service user sounding board earlier this year, a second group was established to gather feedback on our service and processes from stakeholders in the health sector.

Members include a health board chief executive and chair, chief nursing officer, Ombudsman liaison officers, a medical director and representatives from the British Medical Association and NHS Confederation. The group had some useful discussions around a variety of topics including:

- Compliance and redress
- Clinical advice
- Time limits for complaining to the Ombudsman
- Sharing best practice.

Committee Appearances

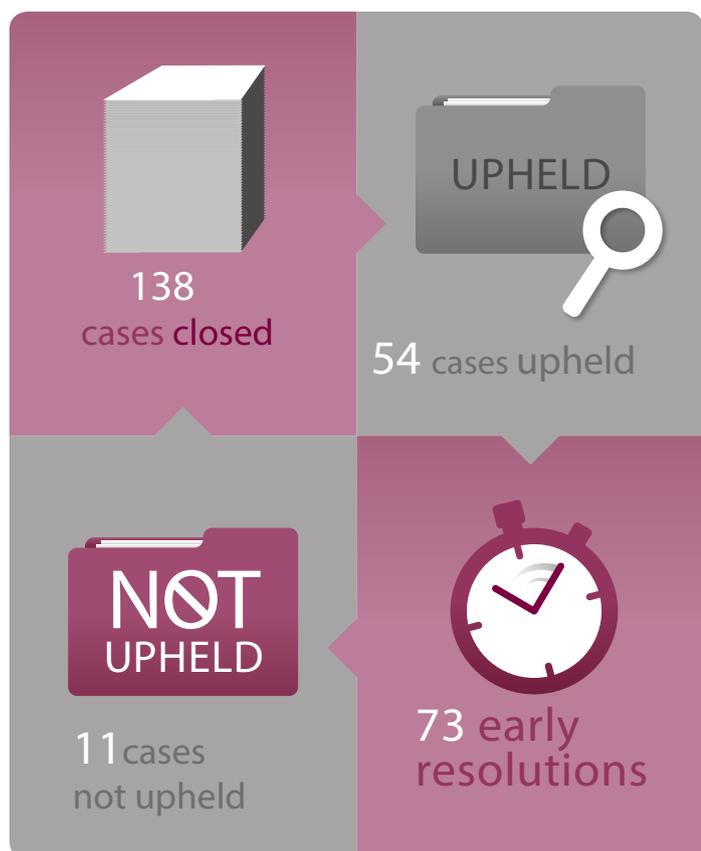
The Ombudsman was pleased to appear in front of the National Assembly's Finance and Equality, Local Government and Communities Committees.

Following scrutiny of the PSOW's Financial Estimate for 2017-18 the Finance Committee concluded it "...to be both prudent and acceptable" and welcomed the Ombudsman's evidence.

Contents

Health	3
Benefits Administration	37
Complaints Handling	38
Education	45
Environment and Environmental Health	46
Housing	48
Planning and Building Control	54
Roads and Transport	55
Social Services - Adult	56
Social Services - Children	59
Various Other	62
More information	64

Casebook in numbers



This infographic illustrates the cases closed between October and December 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 summaries relate to public interest reports issued under Section 16 of the Public Services Ombudsman (Wales) Act 2005.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case reference 201504223 – report issued in October 2016

Ms A through her Assembly Member complained to the Ombudsman that the care her father ("Mr M") received post-operatively at Ysbyty Glan Clwyd ("the Hospital") was inadequate, resulting in his death from sepsis. Ms A also complained about the Betsi Cadwaladr University Health Board's ("the Health Board") poor handling of her complaint.

The Ombudsman's investigation found that Mr M had significantly raised CRP levels following surgery. This was a possible indication of a post surgical leak. Mr M's clinical records showed his CRP levels were tested repeatedly, but were not reviewed. The failure to review Mr M's increasingly abnormal CRP levels was a fundamental clinical deficiency, resulting in missed opportunities for earlier intervention. The Ombudsman could not rule out the possibility that, had clinicians intervened sooner, a different outcome for Mr M may have resulted. Ms A's complaint was upheld.

The Ombudsman was critical that it took the Health Board over eight months to reply to Mrs A's complaint. The reply broadly maintained that Mr M's treatment was appropriate. Additionally, he had concerns about the rigour and depth of the Health Board's investigation. He upheld Ms A's complaint.

The Ombudsman recommended that the Health Board should:

- a) provide a fulsome apology to Ms A both for the significant clinical failings and inadequate investigation of her complaint
- b) pay Ms A the sum of £8,000 for the distress and uncertainty caused by the failings identified. The Health Board should also provide a further payment of £350 to Ms A in recognition of the shortcomings in complaint handling
- c) ensure that the guidelines issued by the Association of Coloproctology and the Association of Surgeons are brought to the attention of its medical staff highlighting the importance of recognising that raised CRP levels is a marker that a surgical leak is likely to have occurred
- d) discuss the contents of the Ombudsman's report at an appropriate consultant forum and at junior doctors' teaching sessions
- e) as part of a wider learning process, the Ombudsman's report should be shared with the clinical staff within the colorectal team who delivered the care to Mr M
- f) a copy of the Ombudsman's report should be shared with the Chair of the Health Board and its Patient Safety and Clinical Governance Group.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number 201503554 – Report issued in October 2016

Mr D complained about the care and treatment he received from Betsi Cadwaladr University Health Board ("the Health Board") following his referral to its Urology Service. Mr D, who was subsequently diagnosed with an aggressive form of prostate cancer, complained that there were excessive delays in:

- conducting diagnostic investigations
- scheduling appropriate surgery following his diagnosis
- arranging post-surgical radiotherapy.

Mr D also complained about numerous communication failings and about the Health Board's handling of his complaints about these matters.

The Ombudsman did not find that Mr D's post-operative radiotherapy was delayed but did find that there were excessive delays in conducting diagnostic investigations and in the scheduling Mr D's surgery. The Ombudsman also upheld Mr D's complaint about communication failings and the Health Board's handling of his complaint.

The Ombudsman recommended that:

- a) The Health Board provide Mr D with a fulsome written apology.
- b) The Health Board, in recognition of these failings and of the distress caused to Mr D, make a payment to him of £3,500.
- c) The Health Board urgently review its capacity to provide or to commission template biopsies within 31 days of referral.
- d) The Health Board provide the Ombudsman with an account of how decisions taken at cancer care MDTs are coordinated and disseminated.
- e) The Health Board share this report with the Concerns Team and draws to their attention the complaint handling failings identified.
- f) The Health Board undertake a detailed review of its Urology Service's compliance with the Welsh Government's Referral Guidelines for Suspected Cancer. This review should refer to:
 - action taken in response to the increasing demand for radiotherapy
 - action taken to reduce the backlog of Urology follow-up waiting lists
 - action taken to increase administrative support for Consultant Urologists
 - whether referrals from the pan-North Wales MDT to Merseyside has improved patient pathways in the treatment of urological cancer.

The Health Board agreed to implement these recommendations.

Aneurin Bevan University Health board – Clinical treatment in Hospital

Case number 201503082 - Report issued in November 2016

Mrs X complained to the Ombudsman about the care her father Mr Y received at the Royal Gwent hospital ("the hospital") between Friday 5 December 2014 and over the following weekend after his admission suffering with constipation. Mr Y died on 8 December. Mrs X complained her father's raised blood glucose levels were not managed and he was not seen by a doctor for several hours. Mrs X said that despite her father having a full care package in place at home, he remained on an unsuitable ward and had an undignified end of life. Mrs X also complained that the Aneurin Bevan University Health Board's ("the Health Board") investigation of her complaint had been unhelpful.

The Ombudsman upheld Mrs X's complaints. He found that no action was taken in relation to Mr Y's elevated blood glucose levels over the weekend. Further, nursing staff had not informed the medical team of Mr Y's aspiration or fluctuating swallowing ability (dysphagia). He was not referred to a Speech and Language Therapist ("SALT") and he had not been kept nil by mouth ("NBM") in the interim.

The Ombudsman found that on Sunday, Mr Y's condition deteriorated and he was not reviewed by a doctor for over six hours. Nursing staff had not escalated the failure of a doctor to attend Mr Y. Consequently, antibiotics were not administered in a timely manner. The Ombudsman could not be certain whether earlier intervention might have led to a different outcome for Mr Y. The Health Board had not recognised that Mr Y had a full care package in place at home, and he had been placed on an inappropriate ward.

The Ombudsman did not uphold Mrs X's complaint about her father's end of life on an open ward. Side rooms were in use by patients with priority need.

The Ombudsman found that the Health Board's own investigation of Mrs X's complaint did not identify the failings in Mr Y's care.

In addition to a number of steps it was already taking, the Health Board agreed to implement the following recommendations:

- a) apologise to Mrs X for the identified failings and, in recognition of the distress and uncertainty associated with her father's care, make a financial redress payment of £2000 to her
- b) remind all nursing staff that patients with dysphagia should be referred without delay to SALT and kept NBM until formally assessed
- c) review - with Educational Diabetic Nurse input - whether there are training issues for nursing staff on this ward in relation to the identification and management of hyperglycaemia
- d) escalation -
 - (i) establish why escalation procedures were not followed in this case
 - (ii) review the escalation process, in light of the outcome, to ensure it will be more effective in the future.

OTHER REPORTS - UPHELD

Abertawe Bro Morgannwg University Health Board - Patient list issues

Case Number 201503520 – Report issued in October 2016

Mrs A complained that her mother, Mrs B, had waited too long for hip replacement surgery; that Abertawe Bro Morgannwg University Health Board ("the Health Board") had not responded to requests to expedite Mrs B's surgery; and about the Health Board's complaints handling.

While the Welsh Government's referral to treatment time ("RTT") target was exceeded, the Ombudsman concluded that this, in itself, is not maladministration. However, he identified a number of failings which led him to uphold the complaints:

- the RTT clock was not started at the right time, that is when the Health Board received Mrs B's GP's first referral to it
- there was no clinical re-assessment when Mrs B's GP reported she had increasing symptoms
- Mrs B consequently spent an excessive amount of time on the waiting list
- questions raised by the family about surgery elsewhere were not fully answered.

The Ombudsman recommended that the Health Board apologise and pay 50% of Mrs B's costs for private surgery which she had already funded. Further, that it should ensure that those on waiting lists are made aware of any alternative options for treatment that may be available to them.

Dental Practice in the area of Betsi Cadwaladr University Health Board - Clinical treatment outside hospital

Case Number 201505641 - Report issued in October 2016

Mr M complained about the care and treatment that a dentist provided during an appointment in September 2015. He said the dentist extracted the wrong tooth and the procedure was carried out without his permission. Mr M was also concerned that incorrect information was noted in his records at an appointment in July.

The Ombudsman was unable to definitively conclude whether information was inputted incorrectly at the July appointment. On this basis, he was unable to make a finding on this complaint.

The Ombudsman found that the record keeping for the September appointment was inadequate. In the absence of a treatment plan/consent form or documented diagnosis/explanation of what was seen on examination, the Ombudsman was unable to say whether Mr M's informed consent was obtained to extract the teeth or about the appropriateness of the extraction. He upheld the complaint. He recommended that the dentist:

- a) apologise
- b) pay £300 for the distress caused, and

c) undertake training in record keeping.

Cardiff and Vale University Health Board – Clinical treatment in hospital

Case Number 201600965 – Report issued in October 2016

Mrs Y complained on behalf of her husband (Mr Y) about the care and treatment that he received during a stay at the University Hospital Wales (“the hospital”) and later as an outpatient. Mrs Y said there had been a failure to:

- carry out appropriate investigations after Mr Y had ‘a blackout’ in August 2014
- provide satisfactory and timely follow up
- adequately diagnose Mr Y’s condition and carry out a required procedure in a timely manner.

Mrs Y also said that her subsequent complaint was not satisfactorily managed.

The Ombudsman partly upheld the concern that appropriate investigations had not been carried out after Mr Y had suffered ‘a blackout’. In general he found that the inpatient care had been reasonable but said it was clear in retrospect that adequate cardiology input had not been provided.

The Ombudsman found once Mr Y’s echocardiogram result was known that the follow up was clearly unreasonable. He said there was a lack of urgent referral, a delay in diagnosis and a subsequent delay in carrying out the required procedure. He upheld these elements of the complaint. Fortunately Mr Y did not suffer any clinical detriment but he did suffer a prolonged period where he was worried and concerned about his health.

The Ombudsman also upheld Mrs Y’s complaint about the Health Board’s complaint handling. The Ombudsman recommended that the Health Board:

- a) apologise
- b) provide financial redress (£500 distress and £250 for complaint handling), and
- c) process changes in the cardiology pathway and a review of cardiac waiting lists.

Betsi Cadwaladr University Health Board and Flintshire County Council – Continuing Care

Case Numbers 201502879 & 201503954 – Report issued in October 2016

Mr X complained that allegations of inappropriate behaviour by him towards his carers were not put to him to respond to and were not properly investigated. Mr X also complained he had been denied the option of arranging his own carers using Direct Payments and had been left without carers for two years. Finally, Mr X complained that there were disproportionate delays in handling his complaint.

The Ombudsman found that the allegations had not been handled or investigated appropriately. He also found that Mr X’s request for Direct Payments had not been appropriately considered. The Ombudsman concluded that Mr X had been avoidably left without care input for two years and that Betsi Cadwaladr

University Health Board ("the Health Board") and Flintshire County Council ("the Council") had failed to make an appropriate offer of care. Finally, he found that complaint handling had been poor and disproportionately delayed.

The Ombudsman recommended procedural changes in relation to the handling of such allegations, a reconsideration of Mr X's needs and how these would be met. He also recommended that apologies should be made and that the Health Board and Council should pay Mr X redress in the sum of £2300 and £1450 respectively, in recognition of the shortcomings identified.

Cardiff and Vale University Health Board – Clinical treatment in hospital Case Number 201506359 – Report issued in October 2016

Mr X had an operation to repair an abdominal hernia (the protrusion of an organ or part of an organ through the abdomen) in April 2014. He complained about whether it was appropriate for the surgeon not to use mesh during the operation. Polypropylene mesh is a synthetic material used in hernia repair. He questioned whether the decision not to use mesh would have had a detrimental effect on the success of a second hernia repair procedure, carried out in January 2015.

The Ombudsman decided that it was a matter for Cardiff and Vale University Health Board ("the Health Board") as to which method it used to repair Mr X's hernia. However, in reaching its decision, the Health Board should have taken into account all relevant factors. There was insufficient evidence to conclude that the Health Board had done so and the Ombudsman partially upheld the complaint.

The Ombudsman decided that there was insufficient evidence to conclude that the second operation would not have been required, due in part to a lack of comprehensive operation notes. The Ombudsman did not uphold this part of the complaint.

The Ombudsman recommended that the Health Board should:

- a) apologise to Mr X
- b) make Mr X a payment of £500, and
- c) that all relevant surgical staff be reminded of the need to make adequate records.

The Health Board agreed to implement the recommendations.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital Case Number 201506609 – Report issued in October 2016

Mrs B complained about the care and treatment her mother ("Mrs C") received by Abertawe Bro Morgannwg University Health Board ("the Health Board") between 8 June and 19 August 2013. In particular Mrs B raised the following concerns:

- a) Mrs C's anticoagulant medication ("Warfarin") was not appropriately managed

- b) the nursing care provided to Mrs C was not of an acceptable standard, and
- c) communication with Mrs C and her family was inadequate.

The Ombudsman found that Mrs C's Warfarin was appropriately managed by the Health Board. He found failings in relation to the nursing care provided to Mrs C. In particular, he found that the management of Mrs C's oral hygiene was below an acceptable standard. He also found that an incident on 11 July, whereby Mrs C caught her fingers in a lifting hoist, could have been avoided. The Ombudsman made four recommendations in relation to these failings.

- a) Provide Mrs B with a written apology for the failures identified in this report, in particular, for its failure to ensure that Mrs C was appropriately protected when using the lifting hoist
- b) Remind staff involved in this complaint of the importance of comprehensive and accurate record keeping and ensuring that all relevant information is conveyed to the patient and family members
- c) Review the 'monitoring mouth care' form, and
- d) Review the falls risk assessment documentation to ensure that it prompts care interventions and provides evidence that all risk factors have been considered and steps have been taken where appropriate to mitigate any risk.

Finally, the Ombudsman did not uphold Mrs B's complaint about communication.

A GP surgery in the Hywel Dda University Health Board area – Clinical treatment outside hospital Case Number 201507114 – Report issued in October 2016

Ms A complained that a GP Surgery ("the Surgery") failed to fully assess her late mother ("Mrs B") between 18 September and 19 October 2015, which resulted in a delayed detection of cancer.

The Ombudsman found that the Surgery did not appropriately investigate the cause of Mrs B's symptoms in accordance with NICE guidelines and that further investigations should have been conducted. Whilst this would not have altered the eventual sad outcome, the Ombudsman recognised the distress caused to Mrs B and her family.

The Ombudsman recommended that the Surgery:

- a) offer Ms A and her family a written apology for its failure to conduct a full investigation of Mrs B's symptoms;
- b) remind its staff of the importance of adhering to relevant NICE guidelines.

Cardiff and Vale University Health Board – Clinical treatment in hospital Case Number 201506362 – Report issued in October 2016

Mr M complained about the standard of treatment provided to his partner, Ms S, by the gynaecology

department at University Hospital Wales. ("the Hospital") An endometrial biopsy was carried out to investigate gynaecological symptoms. It subsequently transpired that Ms S was pregnant but sadly she later miscarried. Mr M complained that the biopsy should not have taken place.

The clinical advice obtained during the investigation was clear that an endometrial biopsy should not have been carried out. It was recorded that Ms S was trying to conceive and there was no recorded date for her last period. Whilst Ms S had not missed a period, and a pregnancy test may not have revealed the pregnancy as it was so recent, the fact that she was actively trying to conceive should have prompted the consultant not to undertake the procedure. The Ombudsman upheld the complaint. However, he concluded that the miscarriage was unlikely to have resulted from the biopsy due to the length of time that the foetus was seen to be progressing in the interim.

Cardiff and Vale University Health Board ("the Health Board") also accepted that there was a delay in transferring Ms S from an examination couch to a bed following her miscarriage.

The Health Board accepted the Ombudsman's recommendations that:

- a) the Health Board should apologise for the identified shortcomings
- b) the consultant should reflect on the case and highlight and discuss it as part of the consultant appraisal process.

Betsi Cadwaladr University Health Board – Clinical treatment outside hospital Case Number 201502829 – Report issued in October 2016

Mr C complained that community nursing staff, employed by Betsi Cadwaladr University Health Board ("the Health Board"), failed to care for his late wife, Mrs C, appropriately. He also said that the Health Board had not explained the delay, associated with its written response to his complaint about this issue, adequately.

The Ombudsman partly upheld the clinical aspects of Mr C's complaint because he found that the Health Board had not ensured that a Community Nurse visited Mrs C, as required. He upheld the complaint handling part of Mr C's complaint because he determined that the Health Board's response to his complaint had been unreasonably delayed, inadequate and misleading.

He recommended that the Health Board should:

- a) write to Mr C to apologise for the failings identified
- b) demonstrate that the transfer system used, by its 'Community Nurse Case Management Service' ("the NCM Service"), is robust
- c) introduce arrangements for ensuring that the NCM Service's patients receive prompt and written notification when their care is being transferred from one Nurse Case Manager to another
- d) formally review its complaint handling in this case
- e) take the action needed to prevent the recurrence of any practice issues identified, and

f) pay Mr C £250 in recognition of the additional distress that he had experienced because of its complaint handling failings.

The Health Board agreed to implement these recommendations.

Cardiff and Vale University Health Board – Clinical treatment in hospital

Case Number 201503603 – Report issued in October 2016

Mr W complained that Cardiff and Vale University Health Board (“the Health Board”) mismanaged the insertion of his chest drain. He suggested that the Surgical Registrar involved (“the Registrar”) did not refer to his earlier scans and/or X-rays before trying to insert it. He also said that she did not use ultrasound guidance during her insertion attempts. He indicated that she had punctured his liver as a result. He reported that she had not given him enough anaesthetic when she first tried to insert his chest drain. He also noted that she had made that attempt in a ward treatment room.

The Ombudsman upheld Mr W’s complaint. He found that the Registrar had not taken sufficient steps to minimise the risks associated with the insertion of Mr W’s chest drain. He recommended that the Health Board should

- a) apologise to Mr W for the clinical failings identified
- b) pay him £1,500 in recognition of these failings
- c) demonstrate that its doctors have access to ultrasound guidance ‘out of hours’ and,
- d) provide chest drain insertion training for relevant staff members.

The Health Board agreed to implement these recommendations.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital

Case Number 201502005 – Report issued in November 2016

Mr Y complained that Abertawe Bro Morgannwg University Health Board (“the Health Board”) failed to diagnose Pleural Plaques (“PP” benign fibrous thickening of the lungs) from X-rays in 2003 and 2010. In 2011 Mr Y was diagnosed with PP and in 2014 he asked for his 2010 X-ray to be reviewed. A review of Mr Y’s 2003 and 2010 X rays confirmed PP had been present. Mr Y said the failure to diagnose PP meant he missed the opportunity for a payment of £5000 from the Pleural Plaques Government Compensation Scheme (“the Scheme”) which ended on 31 July 2011. Mr Y also complained his complaint had not been dealt with in a timely manner.

The Ombudsman found that Mr Y’s 2003 and 2010 X-rays should have identified Mr Y’s PP. The Ombudsman noted that PP is not a disease and does not cause physical harm. The Ombudsman found that the failure to identify Mr Y’s PP in 2003 led to an injustice as he was denied the opportunity to claim under the Scheme. Mr Y’s complaint about the Health Board’s complaint handling was not upheld.

The Ombudsman recommended the Health Board:

- a) review its policy so that X-rays report on the presence of PP
- b) pay Mr Y £2500 for the failure to identify, and
- c) inform Mr Y of PP in the 2003 X-ray.

Aneurin Bevan University Health Board – Clinical treatment in hospital Case Number 201504212 - Report issued in November 2016

Mrs L complained about her late son Mr B's care and treatment. Mr B, who had chronic health problems, had a hernia operation in 2013. He was subsequently transferred to a rehabilitation centre in respect of his mobility. Mrs L complained that the hernia operation had caused a change in her son's personality.

She was concerned he had been prescribed too high dosages of magnesium leading to seizures. In 2014, Mr B had a further hospital admission. Mrs L was dissatisfied with the nursing care that her son received with regards to dressings for his badly ulcerated legs, his nutrition and pressure sore care. She was also concerned that there had been a delay in her son having an operation for a perforated ulcer. He later died in the intensive care unit.

The Ombudsman's investigation found no evidence that Mr B had been given excess magnesium during his hospital admission in 2013 and there were no concerns about the hernia operation. The Ombudsman noted that a medical adviser appointed by the Coroner had concluded that appropriate investigations had been carried out on Mr B and that even if he had been operated on sooner for his perforated ulcer the outcome would not have changed. This aspect of Mrs L's complaint was not upheld.

Given Aneurin Bevan University Health Board's ("the Health Board") previously acknowledged failings in nursing documentation the Ombudsman concluded that the medical records as they stood did not give a complete picture of Mr B's care and the extent to which it might have been compromised. The Ombudsman also found shortcomings in the Health Board's handling of Mrs L's complaint. To that extent these aspects of Mrs L's complaint were upheld.

The Ombudsman recommended that:

- a) the Health Board's Chief Executive apologise for the failing; and
- b) the Health Board should remind staff of their professional obligations in respect of record keeping.

Cardiff and Vale University Health Board – Clinical treatment in hospital Case Number 201504773 - Report issued in November 2016

Mrs D complained to the Ombudsman that Cardiff and Vale University Health Board ("the Health Board") had failed to arrange for her mother, Mrs M, to receive a surgery called a pelvic exenteration procedure to remove her vaginal cancer in a timely manner and that it had failed to explain the provisional nature of the date initially proposed for the procedure. She also complained that it had failed to explain why the operation had had to be cancelled. Clinicians eventually decided not to proceed with the procedure as the disease had progressed too far. Mrs M died later from the cancer.

The Ombudsman found that there had been a longer delay than one could have hoped for following the decision to perform the procedure. However, the Ombudsman concluded, based on his clinical advice that this delay would have had no impact on Mrs M's eventual outcome. He did however find that the Health Board had failed to ensure that Mrs M was aware that the initial date provided for her procedure was provisional and that it had also failed to explain why the procedure had had to be cancelled.

The Ombudsman recommended that the Health Board should apologise to Mrs D for the latter failings.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case Number 201505705 - Report issued in November 2016

Mrs S complained to the Ombudsman about a delay by her mother's GP Practice (which was managed by Betsi Cadwaladr University Health Board ("the Health Board")) in identifying that her mother had cancer of the gall bladder. She considered that there were signs that her mother, Mrs O, had cancer which the GPs should have identified and arranged for her to be referred to secondary care. She was also unhappy about the care her mother received in a local community hospital and in particular felt aggrieved at the manner in which nursing staffed had pressurised her to arrange for her mother to be transferred to a nursing home.

Finally, Mrs S was concerned about the manner in which the Health Board responded to her complaint and the delays she experienced.

The Ombudsman found that the GPs who saw Mrs O acted appropriately and that whilst a lesion indicative of a cancer was not identified as such, this was a very unusual presentation which few GPs would have seen previously. Accordingly, he did not uphold this aspect of the complaint. The Ombudsman had some sympathy with Mrs S for the manner in which she was repeatedly asked to find a care home for her mother at what was a difficult time and in view of Mrs S's personal circumstances. However, despite these concerns, as the actions of staff were in keeping with the Health Board's discharge policy, the Ombudsman made no finding on this issue.

Finally, the Ombudsman identified shortcomings in relation to the Health Board's handling of Mrs S's complaint and upheld this element of the complaint. He recommended that the Health Board:

- a) apologise to Mrs S
- b) pay her redress of £350; and
- c) amend one of its procedures.

Abertawe Bro Morgannwg University Health Board – Clinical treatment outside hospital

Case Number 201505899 - Report issued in November 2016

Ms X complained about the care and treatment that she received from Abertawe Bro Morgannwg University Health Board's ("the Health Board") mental health services between January and November 2014. Ms X said that during a mental health assessment in March 2014, an inappropriate comment about self harm was made. Ms X also complained that there was a lack of support following attempts to self harm and following an incident of domestic abuse. Ms X complained that a diagnosis of menopause in June 2014

had been unreasonable. Finally, Ms X complained that there had been a failure to address her concerns in accordance with the complaints process.

The investigation found that on the balance of probability, it was likely a comment had been made which had caused Ms X distress. The investigation also found that whilst Ms X had been provided adequate support following her periods of crisis, there had been a failure to fully explore the allegations of domestic abuse and provide specific support. The investigation found that whilst Ms X was informed that she was perimenopausal, the diagnosis was in conjunction with the diagnosis of depression, it was not an alternative diagnosis. Finally, the investigation found that despite numerous letters and meetings, the Health Board had failed to address Ms X's concerns

It was recommended that the Health Board:

- a) apologise to Ms X
- b) pay her £150 in recognition of the time and trouble in bringing her complaint to this office
- c) review the complaint handling in this case, and the lessons learned and create an appropriate action plan
- d) Finally it was recommended that officers were reminded of the need to ensure concerns of domestic abuse are fully recorded and that appropriate support is offered.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201503339 - Report issued in November 2016

Mr F complained that Betsi Cadwaladr University Health Board ("the Health Board") had deliberately and unnecessarily delayed a shoulder operation, which his wife, Mrs F, needed. He also said that its response to his complaint, about this, was unjustifiably delayed.

The Ombudsman partly upheld the clinical aspect of Mr F's complaint. He established that the Health Board had made an unnecessary cardiology referral and removed Mrs F's name from the relevant waiting list when it should not have done so. He also found that it had failed to communicate effectively with Mrs F about its waiting list-related actions and taken too long to complete her shoulder operation. He upheld the complaint handling element of Mr F's complaint. He determined that the Health Board's written response to his complaint was inadequate and unreasonably delayed. He recommended that the Health Board:

- a) should write to Mr and Mrs F to apologise for the failings identified; and
- b) improve its arrangements for communicating with patients about their waiting list positions.

The Health Board agreed to implement these recommendations.

A GP Practice in the area of Cwm Taf University Health Board – Clinical treatment outside hospital Case Number 201504421 - Report issued in November 2016

Mrs D complained about the care and treatment her late mother, Mrs M, received from her GP. Mrs D said,

despite presenting with abdominal pain, there was a delay in conducting any investigation or referring Mrs M to secondary care services, which resulted in Mrs M paying for a private consultation; where Mrs M was diagnosed with cancer of the colon. Mrs D also complained about the GP's failure to discuss an abnormal blood test result with Mrs M and, in her view, the Practice's ongoing failure to ensure that subsequent patients received their test results promptly. Finally, Mrs D complained that the Practice had failed to adequately deal with her complaint.

The Ombudsman found that Mrs M's symptoms should have been investigated or referred to secondary care some eight months earlier and that whilst one could not be certain that an earlier referral would have resulted in a different outcome for Mrs M, it was possible that earlier action may have improved her chances for survival. The Ombudsman also found that the abnormal blood test result should have been discussed with Mrs M and her family. Finally, the Ombudsman found that the complaint handling had been reasonable under the circumstances.

The Ombudsman recommended that:

- a) the GP responsible for Mrs M's care at that time pay for the cost of Mrs M's private consultation, and
- b) that the same GP pay redress of £1000 to Mrs D for the uncertainty as to whether earlier action on the part of the GP would have resulted in a different outcome.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital **Case Number 201506779 - Report issued in November 2016**

Mrs X complained about the care and treatment her late mother, Mrs Y, received from Betsi Cadwaladr University Health Board ("the Health Board"). Specifically, Mrs X complained of poor hygiene care, a failure to monitor Mrs Y's fluid output, poor communication with Mrs Y and her family and the decision to transfer Mrs Y's care to an alternative hospital. Finally Mrs X complained that the Health Board had failed to adequately respond to her complaint.

The investigation found that whilst Mrs Y's hygiene needs had been met, there had been a failure to monitor her fluid balance and nutritional intake. The investigation also found that whilst Mrs Y no longer required acute care, her transfer to the second hospital was not appropriately planned, with no nurses available to provide the specialised wound care she required.

The investigation found that communication with Mrs Y and her family had been poor, although an improvement was noted following a deterioration in Mrs Y's health. Finally, the investigation found that the Health Board had failed to respond to Mrs X's complaint within the timeframe specified by its complaints process.

It was recommended that the Health Board:

- a) write to Mrs X and Mr Y apologising for the failings identified
- b) pay Mrs X £250 for the time and trouble in bringing her complaint to this office

- c) remind staff of the need for regular communication with family members and the need for completing fluid and nutrition charts
- d) ask relevant staff to reflect on the circumstances of this complaint and the lessons learned are shared with Mrs X and Mr Y.

Aneurin Bevan University Health Board - Clinical treatment in hospital Case Number 201600421 - Report issued in November 2016

Mrs X complained about the maternity care that she received at the Royal Gwent Hospital in July 2015. She said that the Surgeon failed to explain all the risks during the process of consenting and continued to proceed with the operation despite the medication not being sufficiently effective. Mrs X said that she suffered with wound dehiscence (wound breaking open) due to poor technique which resulted in the need for further surgery. Mrs X also said that Aneurin Bevan University Health Board's ("the Health Board") complaint response was unsatisfactory.

The Ombudsman taking account of advice from his clinical adviser concluded that the consenting process and the management of Mrs X's expression of feeling sensation/pain during the operation were not unreasonable and he did not uphold these elements.

The Ombudsman did however identify that an inappropriate technique may very well have contributed to the negative outcome for Mrs X. Although shortcomings were not apparent from the first operation (caesarean section) notes, the findings recorded at the second operation were highly suggestive that this was the case.

The Ombudsman noted the uncertainty remaining for Mrs X and to that extent he upheld this element of the complaint. He also upheld the concern about the Health Board's complaint response.

The Ombudsman recommended that the Health Board:

- a) apologise to Mrs X
- b) provide financial redress of £1,000 and
- c) review this case for future learning.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital Case Number 201505758 - Report issued in November 2016

Mrs B complained about the treatment received by her mother Mrs C. She said Betsi Cadwaladr University Health Board ("the Health Board") did not diagnose skin cancer at an early stage resulting in delay in treatment. Mrs B complained that Mrs C was not given adequate support when dealing with her illness and that she received poor nursing care. Mrs B also complained about complaint handling.

The Ombudsman found that the medical care and some elements of the nursing care complained about were reasonable. However, he found that Mrs C was not given adequate access to support services and that an incident at hospital during which Mrs C's oxygen was removed, should not have happened. The

Ombudsman also found that there was an avoidable delay in the complaint handling.

The Health Board agreed to implement the recommendations that:

- a) it should apologise for the failings identified
- b) share the report with all staff involved
- c) make improvements to its practices
- d) apologise for the delay in complaint handling and
- e) pay Mrs B £150 in recognition of the time and trouble the delay caused.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital Case Number 201503665 - Report issued in November 2016

Mrs X complained about the care and treatment provided to her late mother, Mrs Y, when she was a patient at the Wrexham Maelor Hospital ("the Hospital") in February 2014. Mrs X complained that Mrs Y was unreasonably left in the Emergency Department ("the ED") for 14 hours; that there was a lack of urgency in managing and treating her condition; that staff failed to properly manage Mrs Y's pain and that communication in respect of Mrs Y's critical condition and prognosis was poor.

The investigation found that whilst it was unreasonable for Mrs Y to have remained in the ED for the length of time that she did, it did not appear to have detrimentally affected her. This element of the complaint was not upheld. The investigation also found that there had been a delay in treating Mrs Y's condition with antibiotics and that the Health Board's own guidelines suggested that other antibiotics should have been used. It is unclear whether timely antibiotic treatment would have made a difference, but the distress caused by the uncertainty as to whether they might have amounted to an injustice to Mrs X. This element of the complaint was upheld. With respect to pain management, there was no contemporaneous evidence that Mrs Y had been suffering pain that had not been addressed. This element of the complaint was not upheld. As regards the communication, the investigation found that staff should have informed Mrs X much sooner than they did about Mrs Y's poor clinical condition. This element of the complaint was upheld.

It was recommended that the Health Board should:

- a) apologise to Mrs X
- b) pay her £1000 for the distress she suffered and
- c) share the findings of the report internally so that lessons were learned.

The Health Board agreed to implement the recommendations.

Abertawe Bro Morgannwg University Health Board – Appointments, admissions, discharge and transfer procedures

Case Number 201503782 - Report issued in November 2016

Mrs X complained that she was on a waiting list for an operation to surgically remove her gallbladder in 2012 but there was an unreasonable delay on the part of Abertawe Bro Morgannwg University Health Board ("the Health Board") in arranging for that surgery to be performed. The surgery was eventually undertaken in November 2015. Mrs X also complained that the Health Board failed to properly address her complaint about the matter.

The investigation found that Mrs X had symptomatic gallstones by September 2013 and that it was not clinically reasonable for her to have had to wait until November 2015 for her surgery. While waiting for the surgery, Mrs X suffered from frequent episodes of pain and vomiting resulting from her condition. This element of Mrs X's complaint was upheld.

The investigation found that while the Health Board's response to Mrs X's complaint could have more clearly addressed the specific issues she had raised, the response could not be considered to be unreasonable. This element of Mrs X's complaint was not upheld.

It was recommended that the Health Board should:

- a) apologise to Mrs X for the delay in arranging the surgery, and
- b) make a payment to her of £750 as redress to reflect the avoidably prolonged symptoms from which she suffered.

The Health Board agreed to implement the recommendations.

Aneurin Bevan University Health Board – Clinical treatment in hospital

Case Number 201504742 - Report issued in November 2016

Mr X complained that a procedure undertaken to treat his haemorrhoids, by injection sclerotherapy (where a chemical solution is injected into the haemorrhoids to reduce pain and the size of the haemorrhoids) in August 2015, resulted in him suffering painful complications and side effects. Mr X said that he suffered from prostatitis (inflammation of the prostate gland); he experienced severe pain and he had other problems associated with his urinary system. He considered that the procedure might also have caused cancer of the bladder. He said he was unaware of the risks of injection sclerotherapy.

The investigation found that there was insufficient evidence to prove that Mr X was informed of the risks associated with the procedure and therefore insufficient evidence to conclude that informed consent for the procedure was properly obtained. The failure to obtain informed consent for the procedure amounted to maladministration on the part of Aneurin Bevan University Health Board ("the Health Board"). Mr X was denied the right to make an informed decision regarding his treatment and he suffered from unpleasant symptoms which he might otherwise have avoided. The complaint was therefore upheld.

It was recommended that the Health Board:

- a) apologise to Mr X

b) make a payment of £2000 as redress, and

c) share the report with the clinician who undertook the procedure and other clinicians who undertook procedures of this kind so that lessons could be learned.

A Dental Practice in the area of Hywel Dda University Health Board – Clinical treatment outside hospital Case Number 201600242 - Report issued in November 2016

Mrs A complained about treatment provided by a dentist ("the Dentist") at a dental practice in the area of Hywel Dda University Health Board ("the Practice"). She complained that root canal treatment was not properly carried out and temporary fillings were used. She said an infection and the need for remedial treatment by a private dentist resulted.

The Ombudsman found that the Dentist used a temporary filling on one tooth and no follow up for it to be replaced permanently was made. He also found poor practice in relation to the root canal treatment carried out by the Dentist, which required remedial treatment.

The Ombudsman recommended that the Practice should:

a) apologise to Mrs A

b) pay her financial redress of £200 in recognition of the avoidable symptoms she experienced and the need for remedial treatment, and

c) reimburse the cost of the remedial treatment.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital Case Number 201504431 - Report issued in November 2016

Mrs X complained about her three admissions at Ysbyty Gwynedd. She said that during her first admission (4 September 2014) with a blocked gallstone, the endoscopy procedure was cancelled until the doctor returned from holiday and she was only seen by junior doctors during this admission. She said that during her second admission (5 November) with a suspected blocked gallstone, her gall bladder was found to be inflamed. Mrs X said only her insistence led to its removal. During Mrs X's third admission (14 January 2015) with abdominal pain, she said the pain was a result of her common bile duct being cut too wide.

At Mrs X's first admission, the Ombudsman did not uphold the complaint that the ERCP was delayed, nor that Mrs X had not been medically reviewed in her Consultant's absence. The Ombudsman upheld that a stent had been misplaced and recommended Betsi Cadwaladr University Health Board:

a) apologise to Mrs X within a month of the final report, and

b) within three months, review why the stent had been misplaced.

The Ombudsman did not uphold any aspect of Mrs X's complaint about her treatment during her second

and third admissions.

Cardiff and Vale University Health Board - Clinical treatment in hospital

Case Number 201504653 - Report issued in November 2016

Mrs X complained about Cardiff and Vale University Health Board's ("the Health Board") handling of her complaint concerning her late father, Mr Y's treatment. Mrs X also complained that the Health Board had lost her father's clinical records.

The Ombudsman found that the Health Board had overlooked Mrs X's complaint about her father's treatment and it was unacceptable it had taken 15 months to respond to the complaint. During the course of the investigation, the Health Board located Mr Y's clinical record, which had been missing for over two years.

The Ombudsman recommended that within a month of the final report the Health Board pay Mrs X £750, in recognition of its poor complaint handling and for the delay in locating Mr Y's clinical records.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital

Case Number 201503520 - Report issued in November 2016

Mrs A complained that her mother, Mrs B, waited too long for hip replacement surgery. Further that the Health Board had not responded to requests to expedite Mrs B's surgery. Also, about the Health Board's complaints handling.

While the Welsh Government's referral to treatment time ("RTT") target was exceeded, the Ombudsman concluded that this, in itself, is not maladministration. However, he identified a number of failings which led him to uphold the complaints:

- the RTT clock was not started at the right time, that is when the Health Board received Mrs B's GP's first referral to it
- there was no clinical re-assessment when Mrs B's GP reported she had increasing symptoms
- Mrs B consequently spent an excessive amount of time on the waiting list
- questions raised by the family about surgery elsewhere were not fully answered.

The Ombudsman recommended that the Health Board:

a) apologise

b) pay 50% of Mrs B's costs for private surgery which she had already funded, and

c) ensure that those on waiting lists are made aware of any alternative options for treatment that may be available to them.

Aneurin Bevan University Health Board - Clinical treatment in hospital

Case Number 201505608 - Report issued in November 2016

Mrs A complained about the poor nursing care that her father ("Mr M") received while an inpatient at the Royal Gwent Hospital ("the Hospital") between December 2013 and March 2014. Her concerns included poor communication and the ward in which her father was being cared for being unhygienic and untidy. Mrs A also complained about poor/inaccurate record keeping by nursing staff.

The Ombudsman's investigation concluded that whilst some aspects of Mr M's nursing care were broadly reasonable and tailored to his needs, there were instances when the care fell below reasonable standards. Areas where shortcomings were identified included Mr M's cannula care and the failure to put in place a care plan to manage his infection. The Ombudsman was also concerned that the records for some periods of care were so poor that it was not possible to comment on the quality of nursing care delivered to Mr M. Mrs A's complaint was upheld.

The Ombudsman recommended that Aneurin Bevan University Health Board ("the Health Board") provide a written apology to Mrs A for the failings identified during the investigation as well as detailing the measures it had put in place to address the failings. Additionally, the Health Board agreed to make a payment of £500 to Mrs A for the distress caused to her.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital

Case Number 201504423 - Report issued in November 2016

Miss B complained about the care and treatment she received at Morriston Hospital following her transfer of care from another Health Board in October 2014. She complained there was a delay in diagnosis and treatment of the cause of her symptoms. She also complained that she only found out in June 2015 that a multi-disciplinary panel determined in August 2014 that she may have cancer in the bile duct and should have received surgery but she still did not know whether she had cancer. Finally, she complained about the delay in receiving Aneurin Bevan University Health Board's ("the Health Board") response to her complaint, which she said did not deal with all the issues she raised.

The Ombudsman concluded that, overall, the investigations and treatment of Miss B were appropriate and timely. He found that the clinical situation was discussed with Miss B at various consultations, including explanations about the clinical picture. He did not uphold these complaints. However, he found that there was a delay in responding to Miss B's complaint. Further, whilst the Health Board had, in the main answered her concerns, some issues had not been addressed. He upheld this complaint. The Health Board agreed to apologise and offer a payment of £250 in recognition of the distress caused by the shortcomings in its complaints handling.

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

Case Number 201504714 - Report issued in November 2016

Mr G complained about the length of time (the Referral to Treatment or 'RTT' time) that he had to wait for hernia repair surgery.

The Ombudsman found that there were 69 weeks between the receipt of the GP referral letter until Mr G's surgery, which is way in excess of the maximum 36 week time limit. Part of the excess time related

to the fact that Mr G initially had a private appointment with the consultant to verify his need for surgery. Therefore the RTT rules indicated that the RTT clock started again. However, the Ombudsman found that during the wait for surgery, Mr G's hernia had worsened and was symptomatic. He had two visits to A&E, and his GP wrote to the hospital on several occasions following consultations with him. His priority for surgery should have been reassessed, and it was not. The Ombudsman also expressed concern about the resources taken up in managing patients on lengthy waiting lists for surgery.

The Ombudsman upheld the complaint. There was clinical evidence about poorer outcomes of emergency surgery and this was statistically more likely in symptomatic hernia patients. Mr G's priority for surgery should have been reassessed. The Ombudsman recommended that Abertawe Bro Morgannwg University Health Board should:

- a) apologise to Mr G
- b) make a financial redress payment of £600.

It also agreed to review, within six months, whether the action that it had taken to reduce waiting times for general surgery had been effective.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201600278 – Report issued in December 2016

Mrs P complained about the care and treatment provided by Betsi Cadwaladr University Health Board ("the Health Board"). In particular:

- a) The Health Board failed to communicate the outcome of the surgery, conducted on 4 September 2014, with Mrs P
- b) A nurse failed to treat Mrs P with dignity and respect on 7 September; and
- c) Relevant records detailing Mrs P's surgery were not available to clinicians when she attended the Emergency Department on 12 September.

In relation to complaint a) the Ombudsman found that the surgery conducted on 4 September differed from what was stated on the consent form that Mrs P signed. There was no evidence that the outcome of that surgery was communicated to Mrs P. He recommended that the Health Board:

- a) provide Mrs P with a written apology and a financial payment; and
- b) that the Consultant involved was reminded of good practice.

In relation to complaint b), the Ombudsman was satisfied that the Health Board had accepted that it failed to treat Mrs P with dignity and respect and that it had apologised to Mrs P for this failure. He was also satisfied that the Health Board was in the process of putting procedures in place to prevent similar incidents in future. He asked to see evidence of progress made in this regard.

Finally, the Ombudsman did not uphold complaint c) on the basis that Mrs P's records were requested

within a reasonable timeframe and the treatment provided to her was appropriate.

**Betsi Cadwaladr University Health Board - Clinical treatment outside hospital
Case Number 201505932 - Report issued in December 2016**

Mr Y complained about the care and treatment he received from Betsi Cadwaladr University Health Board's ("the Health Board") Adult Psychiatry Team between May 2012 and June 2014. Specifically, Mr Y complained that there had been a failure to monitor the effect of anti psychotic medication on his physical and mental health and recognise the side effects. Mr Y also complained that there had been a failure to review his medication. Finally Mr Y complained that there had been a failure to adequately respond to his complaint.

The Ombudsman found that Mr Y's mental health had been stable for the majority of the period he had been taking the anti psychotic medication and that it was reasonable for clinicians to consider alternative reasons for Mr Y's symptoms of memory loss, lethargy and dizziness. He also found that Mr Y's medication had been reviewed regularly and was amended when appropriate. Finally the Ombudsman found that there had been an unnecessary delay on the part of the Health Board in acknowledging Mr Y's complaint.

The Ombudsman recommended that the Health Board:

- a) apologise to Mr Y for the failing identified; and
- b) remind investigation officers of the importance of the timely acknowledgement of a complaint.

**Betsi Cadwaladr University Health Board – Clinical treatment outside hospital
Case Number 201505581 - Report issued in December 2016**

Mrs X complained about the care and treatment she received from Betsi Cadwaladr University Health Board's ("the Health Board") Mental Health Services. Mrs X said that despite ongoing requests for help there was a failure to appropriately assess her needs and provide the necessary support. Mrs X also complained that communication with the Health Board had been poor and that there had been a failure to adequately respond to her complaint.

The Ombudsman found that the Health Board had failed to provide Mrs X with the details of decisions made about her care and the reasons for those decisions which left her feeling unsupported and distressed.

The Ombudsman recommended that the Health Board:

- a) apologise to Mrs X
- b) pay £250 in recognition of the time and trouble taken to make the complaint; and
- c) remind officers about the need for communication with patients and families about the decisions made about treatment.

Cwm Taf University Health Board – Clinical treatment in hospital Case Number 201504544 - Report issued in December 2016

Ms D and Ms E complained about failings in the medical and nursing care that their late mother, Mrs M, received following her admission to the Royal Glamorgan Hospital in February 2014. Mrs M underwent a series of investigations to identify the source of an underlying infection but, sadly, passed away while undergoing a procedure, under general anaesthetic, to aspirate infected endometrial fluid. A post-mortem revealed that the source of Mrs M's infection was an undetected non-Hodgkin Lymphoma (NHL).

Ms D and Ms E complained that clinicians failed to diagnose Mrs M's condition of NHL and failed to adequately investigate and treat her signs of sepsis. Ms D and Ms E also complained that clinicians failed to consult with the family before carrying out the surgical procedure and failed to take Mrs M's frailty into account in administering a general anaesthetic.

Ms D and Ms E complained about a range of failings in Mrs M's nursing care and about Cwm Taf University Health Board's ("the Health Board") handling of the family's complaint.

The Ombudsman found that Mrs M's condition of NHL was extremely rare and could not have been detected (from tests and scans) prior to the post-mortem. The Ombudsman also found that Mrs M's condition of sepsis was properly treated and that clinicians did take Mrs M's frailty into account in their decision to conduct the surgical procedure under general anaesthetic. The Ombudsman considered that, as Mrs M's condition was life-threatening, clinicians could not have delayed their intervention in order to discuss the procedure more fully with the family. However, the Ombudsman found that there were failings in elements of Mrs M's nursing care and in the Health Board's complaint handling.

The Ombudsman recommended that the Health Board:

- a) provide the family with a fulsome written apology that recognises the nursing, nurse record keeping and complaint-handling failings identified in the report
- b) that an Action Plan should be drawn up to address the identified shortcomings in nursing care; and
- c) in recognition of the distress and inconvenience to the family in pursuing its complaint about these matters at a time of bereavement, that the Health Board made a payment of £250 each to Ms D and Ms E.

The Health Board accepted the Ombudsman's findings and agreed to implement his recommendations.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201600781- Report issued in December 2016

Mrs X complained about the delay in diagnosing her father, Mr Y, with encephalitis, and the attitude of the Consultant in charge of his care. Mr Y was admitted to hospital following a fall; he had recently become confused and was being treated for an urinary infection in the community. He underwent tests and was treated for an infection before being transferred to a community hospital for rehabilitation. However, his condition did not improve and he was transferred back to the general hospital.

The Ombudsman found that, although there had been a delay of one two weeks in diagnosis, encephalitis

is an extremely rare condition and delays in diagnosis are common. He could not conclude that such a delay amounted to a service failure. However, he did find that Mr Y should not have been transferred to the community hospital because at that time his condition had not improved, and his CRP level (a blood test marker for inflammation) had actually increased in the days preceding the transfer. The Ombudsman could not reach a conclusion regarding the attitude of the Consultant. As Betsi Cadwaladr University Health Board ("the Health Board"), and, in particular the Consultant involved, had learned from the complaint, the only recommendation the Ombudsman made was for the Health Board to apologise to Mrs X.

Cardiff and Vale University Health Board – Clinical treatment in hospital Case Number 201600347 - Report issued in December 2016

Mr X said that on 7 June 2015, he attended the Emergency Department (ED) at the University of Wales Hospital, with chest pain and was discharged to await an outpatient cardiac scan. On 10 June he returned suffering chest pains and was sent home on 11 June. Mr X complained that ED staff told him as he had firstly spoken to his GP; the GP should have called the Hospital before he attended. On 13 June, Mr X suffered a heart attack and he complained that if he had an angiogram two days earlier it would have prevented the emergency stent procedure.

The Ombudsman found that at Mr X's second admission he should have been admitted for inpatient investigation. Mr X's complaint about the ED staff was not upheld. The Ombudsman recommended Cardiff and Vale University Health Board

- a) apologise to Mr X for the failure to admit him as an inpatient
- b) pay him £500 because he did not receive a cardiology review at the second admission in recognition of the distress caused by the failures
- c) remind ED physicians that a diagnosis of Acute Coronary Syndrome should be absolutely excluded
- d) apologise to Mr X for not providing an opportunity to discuss his concerns with the Cardiology Team, its letter to Mr X was contradicted by its response to the Ombudsman
- e) pay £500 to reflect his time and trouble in pursuing the complaint
- f) ensure that the Cardiology Team attend to review all relevant referrals at ED; and
- g) remind physicians they have responsibility for a patient's care unless formally transferred to another team and accepted.

NOT UPHELD

Hywel Dda University Health Board – Continuing Care Case Number 201504109 - Report issued in October 2016

Ms S complained about what she felt were inadequacies in the way her late mother's retrospective

Continuing NHS Healthcare ("CHC") was considered. In particular, Ms S was unhappy that the Independent Review Panel ("IRP") had only found her mother eligible for CHC for a limited period and felt that the IRP had not taken into account the family's views. Finally, Ms S was unhappy that Hywel Dda University Health Board ("the Health Board") had failed to carry out a proper assessment of her mother's healthcare needs prior to her discharge from a mental health ward to a care home.

The Ombudsman's investigation concluded that the retrospective CHC claim/process, was handled reasonably and was in line with the clinical evidence. He also concluded that even if Ms S's mother had been assessed for CHC prior to her discharge from hospital, there was no reason to believe that eligibility for CHC would have been found at that stage. He did not uphold Ms S's complaint.

The Ombudsman also did not uphold Ms S's complaint that the IRP had not considered the family's views at the hearing.

Cardiff and Vale University Health Board - Clinical treatment outside hospital Case Number 201506147 – Report issued in October 2016

Miss X complained about failings in the support she received from the Community Mental Health Team, including in relation to her medication regime, the format of her therapy and the staff involved in her care. She said that her mental health had deteriorated as a result of these failings.

The Ombudsman found that the care and treatment Miss X had been provided with was appropriate, although there were some limited shortcomings in the quality of Cardiff and Vale University Health Board's ("the Health Board") communication with her. The Ombudsman did not, however, consider that these materially affected the overall adequacy of her care and treatment. The Ombudsman did not uphold the complaint.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201506864 – Report issued in October 2016

Ms W complained about the treatment she received following her emergency admission with acute abdominal pain and vomiting. The complaints subject to investigation were that the cause of an abdominal perforation was not found after three operations were carried out by what Ms W considered to be the wrong type of surgeon, and that it was unreasonable for clinicians not to allow her to be transferred to another hospital closer to her home and family. Ms W also complained that her family had not been kept informed of her progress and their telephone calls were not returned.

The Ombudsman found that Ms W's care was managed appropriately throughout her hospital admission and there was no evidence that her care was unreasonable at any time. The Ombudsman found that no opportunities had arisen when Ms W was well enough to be transferred to another hospital, and efforts had been made to contact Ms W's family. The Ombudsman did not uphold the complaints.

Welsh Ambulance Services NHS Trust - Clinical treatment outside hospital Case Number 201601071 – Report issued in October 2016

Mrs X complained about the care and treatment provided to her husband, Mr X, by the Welsh Ambulance Services NHS Trust ("the Trust") following his attendance by a paramedic and paramedic crew on 7 February 2015. In particular, Mrs X said that the paramedic did not carry out an adequate physical examination of her husband. Mrs X said that the paramedic misdiagnosed Mr X and provided him with the incorrect treatment; he provided salbutamol (for the relief of asthma symptoms) and ibutropium (used to prevent wheezing, shortness of breath, coughing and chest tightness) via a nebuliser (a device for dispensing liquid in a fine spray) and oxygen mask but should have instead provided furosemide (a diuretic that prevents the body from absorbing too much salt). Mrs X said that the paramedic failed to inform the

hospital treating Mr X of the error he made in administering the incorrect drug.

The Ombudsman found that it was likely that the paramedic had carried out an assessment of Mr X. Whilst there was no documentary evidence to support this, the paramedic did provide Mr X with appropriate care and treatment. The Ombudsman did not uphold the complaint. The Ombudsman also found that the treatment provided to Mr X was in accordance with relevant guidelines and was reasonable and appropriate. The paramedic did administer furosemide. The Ombudsman did not uphold the complaint. Given that the Ombudsman did not consider that inappropriate treatment had been provided to Mr X, he did not uphold the complaint that the paramedic had failed to inform the hospital.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital Case Number 201506189 – Report issued in October 2016

Mrs A complained about the care and treatment provided to her late mother, Mrs C, by Abertawe Bro Morgannwg University Health Board ("the Health Board"). In particular she raised the following concerns:

- a) Mrs C was not provided with appropriate treatment for pneumonia (a type of lung infection)
- b) Mrs C was not prescribed insulin (a hormone that allows the body to regulate blood sugar levels) when required, to treat diabetes
- c) the management of Mrs C's fluid intake was inadequate
- d) Mrs C was not treated with dignity and respect, and
- e) there were errors in Mrs C's medical records.

The Ombudsman found that, overall, the management of Mrs C's care and treatment was within the range of acceptable practice. However, he found that the Health Board failed to treat Mrs C with dignity and respect. He considered that the Health Board had already acknowledged this failing and provided Mrs A with an appropriate remedy and therefore no further recommendations were made.

Aneurin Bevan University Health Board – Clinical treatment in hospital Case Number 201601585 – Report issued in November 2016

Mr X complained about the care and treatment provided to his wife, Mrs X, by Aneurin Bevan University Health Board ("the Health Board") regarding management of her diabetes and an inpatient stay at the Royal Gwent Hospital between 8 and 11 April 2015. In particular, Mr X complained that the Health Board failed to communicate adequately with him. He said that he was not informed of his wife's operation on 9 April. Mr X also said that his wife was not well enough to consent to the operation. Mr X said that the Health Board failed to place Mrs X on the correct waiting list for management of her diabetes.

The Ombudsman found that Mr X should have been advised of Mrs X's operation. However, as Mr X had telephoned the ward and obtained the information, there was no injustice. The Ombudsman did not uphold the complaint. The Ombudsman found that Mrs X's blood sugar levels were not too high to have been able to consent to the operation. He did not uphold the complaint.

The Health Board accepted that it failed to place Mrs X on the correct waiting list for an appointment in the diabetic clinic. As there was, however, no evidence that the appointment would have increased Mrs X's quality of life, the Ombudsman did not uphold the complaint.

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

Case Number 201507057 - Report issued in December 2016

Mrs A complained about the care and treatment that her late son received from the GP Practice between October 2012 and September 2013. She questioned why her son's creatinine levels (a chemical waste product in the blood that passes through the kidneys to be filtered and eliminated in urine) were high between 24 January and 12 March 2013 and she wished to know if the creatinine levels in the blood increased when kidney function was abnormal. Mrs A also questioned why given her son's age his stroke was not investigated further. In addition, she was concerned that there was a missed opportunity by the GPs to diagnose her son's cancer sooner.

The Ombudsman's investigation found that the GPs' management of Mrs A's son's care was reasonable and appropriate. He found no evidence on which he could criticise the GPs' management when it came to the care of Mrs A's son. He therefore did not uphold Mrs A's complaint.

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

Case Number 201601516 - Report issued in December 2016

Mr P complained about the treatment his elderly mother, Mrs P, received from the Practice during the period before her death in January 2016. In particular, Mr P complained of the failure to obtain a blood sample from Mrs P in August/September 2015. Mr P also complained about the care and treatment provided to his mother during October/November 2015 when she was treated at home for a chest infection, and prescribed antibiotics. Mr P said that the Practice failed to monitor the effectiveness of this treatment and failed to diagnose the onset of pneumonia.

The Ombudsman found that had a blood test been taken in September, it would not have prevented Mrs P from developing a chest infection in October and would have been unlikely to have altered the course of Mrs P's illness and subsequent admission to hospital. The complaint was not upheld.

The Ombudsman found that Mrs P was reviewed regularly by telephone during October/November, which was considered reasonable and appropriate. Specifically, there was no evidence to suggest a failing on the part of the Practice in diagnosing the onset of pneumonia or that Mrs P suffered any harm as a result of a lack of home visits. The complaint was not upheld.

EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case Number 201603835 – Report issued in October 2016

Mrs X complained that Betsi Cadwaladr University Health Board ("the Health Board") had not responded to her formal complaint which had been made to it four months previously, and that it had not corresponded with her in more than two months.

The Health Board agreed the following in settlement of the complaint:

- a) issue its response to Mrs X's complaint by 31 October 2016
- b) provide a written apology and an explanation to Mrs X for the delay in responding to her complaint or providing her with relevant updates.

Abertawe Bro Morgannwg University Health Board – Patient list issues

Case Number 201603905 - Report issued in October 2016

Mr and Mrs X complained about the communication from Morriston Hospital in relation to waiting list times for dental treatment. Further to this, they complained that they had been offered a meeting to discuss their complaint but had not had any further contact to arrange this.

Whilst no failings were found in relation to providing a written response to the complainants, the Ombudsman found that Abertawe Bro Morgannwg University Health Board (“the Health Board”) had missed correspondence from the complainants. As the opportunity still existed for a meeting to be had to address the complainants’ concerns, the Health Board agreed to the following:

- a) provide a written apology to the complainants for the lack of response to their letter of 23 August
- b) arrange a meeting with the complainants to discuss their concerns in either November 2016 or January 2017.

Oasis Dental Care Limited - Clinical treatment outside hospital

Case Number 201600404 – Report issued in October 2016

Miss A complained about the care and treatment that she received from a dentist (“the Dentist”) when she underwent dental bridge work at one of Oasis Dental Care Limited’s Dental Practices. Although Oasis Dental Care Limited had offered a settlement figure, Miss A said she had incurred additional costs to resolve problems associated with the works.

The Ombudsman’s investigation identified clinical shortcomings in the way that the bridgework had been constructed and executed. He also identified administrative failings around record keeping and complaint handling.

Oasis Dental Care Limited agreed to a settlement figure of £1264 in recognition of the failings caused part of which included the settlement figure it had originally offered to Miss A. In addition, the Dentist was asked to reflect on his clinical practice and Oasis Dental Care Limited was asked to review what lessons it could learn from its handling of Miss A’s complaint.

My Dentist - Dental Centre in the Betsi Cadwaladr University Health Board area - Clinical treatment outside hospital

Case Number 201600016 – Report issued in October 2016

Mr X complained about the care and treatment he received from the Dental Practice. Mr X said the treatment was shabby and had resulted in pain and cysts as well as further decay in his teeth and subsequent problems.

The investigation found that Mr X’s records were inaccurate and unclear. The investigation found that on two occasions there was a failure to undertake full examinations and as a result Mr X experienced unnecessary pain. Finally it was noted that Mr Y required two restorations on the same tooth within a nine month period.

The Dental Practice agreed to apologise to Mr X for the shortcomings identified and order Mr X a free

course of NHS treatment on his upper left tooth to be carried out at a surgery of his choice. The Dental Practice also agreed to pay Mr X £50 in recognition of the pain he had experienced. Finally the Dental Practice agreed to conduct an audit of the Practice's records focusing on accuracy and review Mr X's case, consider the lessons to be learned and feedback the findings to Mr X.

A GP Practice in the area of Abertawe Bro Morgannwg University Health Board Case Number 201601936 – Report issued in October 2016

Mrs X complained that a receptionist at a GP Practice ("the Practice") had improperly questioned her mother's medication prescription with the dispensing pharmacist. When Mrs X complained to the Practice about this, she said she was spoken to rudely and unacceptably by the Assistant Practice Manager. She said the Practice was unwilling to consider her verbal complaint and it was suggested that the patient should consider registering with another GP Practice.

In order to resolve the complaint, the Practice agreed to undertake the following:

- a) apologise to Mrs X for how it handled her complaint and for suggesting that the patient should register elsewhere
- b) review the Practice's complaints procedure to ensure it complies with relevant regulations and guidance
- c) review the Practice's patient removal policy to ensure it complies with relevant regulations and professional guidance
- d) train relevant staff on the revised complaints procedure and patient removal policy.

A GP Practice in the area of Powys Teaching Health Board – Clinical treatment outside hospital Case Number 201603099 – Report issued in October 2016

Mrs A complained about the treatment of her and her son by the Practice. In particular Mrs A raised concerns about difficulties experienced obtaining prescriptions, the former GP's refusal to monitor her blood pressure and communication difficulties with staff at the practice. Mrs A was concerned also by the delay in the provision of the response and said that it did not adequately address her concerns.

Having considered the complaint the Ombudsman was satisfied that the response received from Powys Teaching Health Board ("the Health Board") reasonably addressed some of the concerns raised. However a view was taken that not all of the issues had been appropriately considered and responded to. The Health Board was therefore asked to:

- a) provide a fulsome apology to Mrs A recognising the impact of her experiences
- b) investigate and respond to concerns not addressed previously
- c) make a payment of £250 in recognition of the time and trouble taken to pursue this complaint and the distress caused by the excessive delay.

Rhondda Cynon Taf County Borough Council – Clinical treatment outside hospital

Case Number 201603103 - Report issued in October 2016

Mrs W raised concerns on behalf of her client that Rhondda Community Mental Health Team ("the Team") did not provide adequate support to him and failed to respond to deterioration in his mental health prior to his hospital admission in January 2015. Mrs W's client requested an investigation into the events that led to his hospital admission to explore the breakdown in communication and disjointed approach to his management in the community.

The Ombudsman found that, in balancing the complaint response with plans to move forward with his ongoing support needs, the Team missed opportunities to conclusively respond to the complaint and manage the expectations of Mrs W or her client. Rhondda Cynon Taf County Borough Council agreed with the Ombudsman's recommendations that it would:

- a) apologise for failing to progress the complaint appropriately
- b) provide a full and final response by 1 November 2016.

A GP surgery in the area of Betsi Cadwaladr Health Board - Other

Case Number 201601425 - Report issued in October 2016

Mrs P complained that a GP at the Surgery had behaved in a dismissive manner towards her during a consultation with her on 4 February 2016. She was experiencing problems with sleeping due to her condition and she felt that the GP showed no empathy towards her by suggesting that she should take up yoga and walking. She also raised a concern that the GP prescribed Citalopram for her to take. She believed that medical guidelines state that this should not be taken alongside Duloxetine.

Upon receipt of the complaint the Ombudsman contacted the Surgery and it agreed to:

- a) write to the complainant and invite her to a local resolution meeting with the GPs in order to seek a way forward for her continued treatment. The letter would be sent within 10 working days of the date of the Ombudsman's decision letter
- b) offer her two dates for the meeting within 20 working days of the date of its letter to her.

Cwm Taf University Health Board - Other

Case Number 201603587 - Report issued in October 2016

Mrs S complained that she had not been advised of the possible risks and outcomes of undergoing surgery on a hernia in her right groin. She was, therefore, of the opinion that she had not provided informed consent for the procedure that was undertaken in June 2015. She said that as a result of the procedure she had experienced a lot of pain and numbness in her right groin which had caused her to give up work and affected her family life.

Cwm Taf University Health Board was contacted and agreed to write Mrs S a letter inviting her to a local resolution meeting with relevant staff. The meeting was arranged for a day in October 2016.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number 201603980 – Report issued in November 2016

Mr X complained about a delay in the provision of post operative physiotherapy for his mother following hip replacement surgery in a hospital within Betsi Cadwaladr University Health Board ("the Health Board"). Mr X's mother also suffered from dementia.

Mr X was advised initially that physiotherapy would commence three weeks post operative; however, this was later delayed to eight weeks. Mr X attempted to challenge this decision but found that he was unable to discuss matters with the clinician concerned, who was unavailable and soon afterwards went on leave. Mr X considered that the decision to delay physiotherapy was based on the clinician's availability rather than being in his mother's best interests. Mr X felt that the delay had a detrimental effect on his mother's dementia. Mr X also raised concerns about the way in which his concerns were handled by the Health Board.

Having considered the complaint the Ombudsman concluded that the Health Board's complaint response had not fully addressed Mr X's concerns about the impact of the delayed physiotherapy on his late Mother and noted an error in the complaints response.

The Health Board was therefore within one month to:

- a) provide a meaningful apology to Mr X recognising the distress caused by the error identified in the complaints correspondence
- b) provide a written response to the outstanding concern.

Hywel Dda University Health Board – Clinical treatment in hospital

Case Number 201604110 – Report issued in November 2016

Mrs P complained on behalf of her uncle about complaint handling by Hywel Dda University Health Board ("the Health Board"), prior to his diagnosis of Cancer. Mrs P's uncle made the initial complaint to the Health Board in August 2015 but he sadly passed away shortly thereafter. Mrs P said that, after 14 months she had still not received a response.

The Ombudsman found that the delay in providing a response was unacceptable and amounted to maladministration. However, the Health Board had already acknowledged the shortcoming and provided an apology and an offer of compensation for the delay.

The Health Board agreed to expedite the investigation into the complaint and issue a full response no later than 18 November 2016.

A GP surgery in the Abertawe Bro Morgannwg University Health Board area

Case Number 201604645 – Report issued in November 2016

Mr X complained that the Practice twice lost his prescription, despite a formal complaint being made following the first loss of prescription.

Mr X also complained that reception staff at the Practice were not aware of its complaints procedure.

As Mr X received his prescription later on the same day, the Ombudsman found that there was insufficient

personal injustice for a formal investigation.

In settlement of Mr X's complaint, the Practice agreed the following actions, to be completed by 30 November 2016:

- a) provide a written apology to Mr X for the issue of lost prescriptions being repeated
- b) provide a payment of £50 to Mr X for the time and trouble in making the complaint
- c) track Mr X's next prescription in order to address any ongoing issues
- d) remind reception staff of the Practice's complaints procedure.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201604683 – Report issued in November 2016

Mr A complained about the treatment that was provided to his late wife, Mrs A. Mr A also complained about Betsi Cadwaladr University Health Board's ("the Health Board") delay in issuing its further response to his complaint, as well as the lack of updates in regards to the delay.

The Health Board agreed to complete the following actions by 30 November 2016 in settlement of Mr A's complaint:

- a) provide an apology for the delay in issuing its response and for the lack of updates during the delay
- b) issue its second response to Mr A's complaint
- c) provide a payment of £50 to Mr A for the time and trouble in making his complaint to the Ombudsman.

A dental surgery in the Cardiff and Vale University Health Board area – Clinical treatment outside hospital Case Number 201604834 – Report issued in November 2016

Ms X complained that she paid for private orthodontic treatment as she was dissatisfied with the treatment she had received from the Practice. Additionally, Ms X was concerned that she had raised a formal complaint with the Practice Manager in July 2015 and was yet to receive its response.

The Ombudsman considered that the 16 month delay in responding to Ms X's complaint was unacceptable. The Practice agreed to complete the following actions by 22 December 2016 in settlement of Ms X's complaint:

- a) give a written apology to Ms X for the significant delay in responding to her complaint
- b) provide an explanation for the delay in providing its response
- c) issue its complaint response to Ms X
- d) offer a payment of £400 to Ms X for the time and trouble in raising her complaint to the Ombudsman.

A Health Centre in the Aneurin Bevan University Health Board area – Clinical treatment outside hospital Case Number 201604019 – Report issued in November 2016

Ms X complained about the timeliness of medical referrals completed by the Health Centre. Aneurin Bevan Health Board ("the Health Board") provided a response to her complaint, however the letter issued did not provide responses to every concern that Ms X had raised in her original complaint letter.

Whilst no failings were found in relation to medical referrals already completed by the Health Centre, the Ombudsman found that there was an opportunity to provide a further written complaint response to Ms X addressing the remainder of her medical concerns.

Therefore, the Health Board agreed to provide an additional complaint response to Ms X, addressing the remainder of the medical concerns raised in her original complaint letter.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201604268 – Report issued in December 2016

Mrs A complained about the contents of the letters that were sent to her GP following being seen by the Endocrine Nurse Specialists on her visit to Aran Ward at Ysbyty Gwynedd in October 2015. Betsi Cadwaladr University Health Board ("the Health Board") provided its response to Mrs A's complaint, but she was disappointed that the response did not address all her concerns. Mrs A wrote a further letter to the Health Board but complained to the Ombudsman that the Health Board had failed to respond.

The Ombudsman noted that the Health Board's Complaints Policy did not provide set timescales for sending further responses following the initial complaint response. The Ombudsman therefore concluded the Health Board had not acted contrary to its policy. However, the Ombudsman acknowledged that it was reasonable for Mrs A to expect to receive a response from the Health Board following her further letter.

The Health Board explained that it had intended to provide a response and following discussions with the Ombudsman agreed to do so by 31 January 2017 in settlement of the complaint.

Hywel Dda University Health Board – Patient list issues Case Number 201604157 - Report issued in December 2016

Mr P wrote to the Ombudsman expressing concern about a delay he would have experienced in receiving surgery to treat his cataract problem. As a result of being told that he would have to wait nearly 12 months for his surgery Mr P opted to fund his own private treatment. Mr P complained to Hywel Dda University Health Board ("the Health Board") and whilst he did receive a telephone call from a Health Board staff member to explaining the difficulties the Health Board was experiencing, he did not receive a formal apology or explanation from the Health Board and Mr P considered this to be unsatisfactory.

Following an approach from the Ombudsman the Health Board agreed to write formally to Mr P to apologise for the delay he would have experienced and to explain the reasons for the delays in providing treatment.

Glasfryn Nursing Home – Continuing Care Case Number 201602530 - Report issued in December 2016

Mrs A complained to the Ombudsman that Glasfryn Nursing Home ("the Nursing Home") failed to provide

her with the nursing records for her late husband in support of a claim for re-imburement of NHS funded nursing care which she wished to submit. It appeared at the time that the investigation of the complaint commenced that the records in question had been misplaced.

However, following the start of the investigation the Nursing Home undertook further searches for the records and they were located. The investigation was concluded on the basis that the Nursing Home would arrange to contact Mrs A to discuss arrangements for providing the requested records.

Aneurin Bevan University Health Board – Clinical treatment outside hospital Case Number 201604943 - Report issued in December 2016

Mrs M had surgery on her left foot in December 2013. She complained to the Ombudsman that the aftercare treatment from Aneurin Bevan University Health Board ("the Health Board") was poor and it had dismissed her concerns regarding infection and the operation had left her disabled. Mrs M was also unhappy that a letter she had written to the Health Board after her complaint had been considered had gone unanswered.

The Ombudsman assessed Mrs M's complaint, and whilst he concluded that the majority of her concerns were unfortunately out of time, the Health Board agreed to take the following action to resolve one element of the complaint:

a) provide a substantive response to Mrs M's unanswered letter within 30 days.

Hywel Dda University Health Board - Other Case Number 201604016 - Report issued in December 2016

Mrs A complained about Hywel Dda University Health Board's ("the Health Board") administration of her retrospective application for reimbursement of costs of healthcare treatment in the European Economic Area.

The Ombudsman found that the Health Board had failed to consider Mrs A's application in accordance with the relevant regulations and guidance. The Ombudsman contacted the Health Board and it agreed to consider Mrs A's application afresh.

Aneurin Bevan University Health Board – Clinical treatment in hospital Case Number 201604374 - Report issued in December 2016

Mr C complained that Aneurin Bevan University Health Board ("the Health Board") had failed to refer his wife to a stroke clinic when she was discharged from the emergency department at Royal Gwent Hospital with a diagnosis of suspected Transient Ischaemic Attack ("TIA"). It also failed to advise her that she should not drive in the interim.

He also complained that the Health Board had failed to address the issues raised by his complaint in its response to him.

The Ombudsman considered his complaint and felt that the Health Board had eventually provided a reasonable response but that there were further changes that could be implemented in order to mitigate the risk of a similar incident in future.

The Health Board agreed to write a letter to the complainant providing an action plan detailing:

- a) the changes to its Emergency Department procedures that it had already implemented as a result of his complaint, and
- b) further changes agreed as a result of communications with the Ombudsman's office, i.e.
 - i. Email referrals to stroke clinic where a TIA is suspected
 - ii. Copy of referral to be sent to patient's GP.

This would be completed within 20 working days of the date of the letter.

**A surgery in the area of Cwm Taf University Health Board – Clinical treatment outside hospital
Case Number 201604735 - Report issued in December 2016**

Ms C complained that a doctor at the surgery had failed to issue a prescription to her following a telephone consultation. She also complained that other staff were rude and unhelpful towards her. She felt that the staff had colluded together which had resulted in her receiving a written warning about her behaviour.

Cwm Taf University Health Board agreed to:

- a) write to the complainant within 30 working days of the date of this decision letter and offer her a local resolution meeting at a reasonable time to minimise any disruption to her work.
- b) The meeting would seek the best way forward for her ongoing treatment and consideration of whether the warning regarding her behaviour should remain on her medical record.

The Ombudsman believed that this to be a reasonable resolution to the complaint.

Benefits Administration

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

City and County of Swansea – Other benefits

Case Number 201603586 - Report issued in October 2016

Mrs X complained about City and County of Swansea Council's ("the Council") delay in releasing a 'Houses to Homes' loan. Mrs X also complained about the Council's handling of her complaint.

The Ombudsman found that the Council's Stage 2 response was appropriate in that it fully accepted that there had been "an unacceptable delay" with the progress of Mrs X's application and that it had apologised to Mrs X.

However, the Ombudsman considered that the Council had failed to manage Mrs X's expectations in regards to the timescale of the release of the loan. Due to this, the Council agreed to:

- a) confirm the reduction of fees of £295, which was previously offered by the Council in its Stage 2 response, for the unnecessary delay in responding to Mrs X's application, and
- b) apologise for an email which implied the loan would be released imminently, and an explanation of the timescale involved in processing the 'Houses to Homes' loan.

Rhondda Cynon Taf County Borough Council - Housing Benefit

Case Number 201603684 – Report issued in November 2016

Mrs X complained about the actions and comments of Rhondda Cynon Taf County Borough Council's ("the Council"), which were made to her in a letter, dated 29 June 2016. Mrs X stated she felt the comments were nasty. The comments were made after Mrs X provided the Council with evidence of her additional expenses relating to Housing Benefit.

The Ombudsman contacted the Council and it agreed to provide a payment of £25 to Mrs X in settlement of her complaint.

Complaints Handling

UPHELD

Cwm Taf University Health Board - Health Case Number 201600042 - Report issued in December 2016

Mr M complained to the Ombudsman about the manner in which Cwm Taf University Health Board ("the Health Board") had performed an operation on his foot to fuse the bones of his big toe at its first joint. He was concerned that the procedure had not been performed correctly and that the management of his care following his operation had been inadequate resulting in the failure of the fusion procedure (non-fusion).

The Ombudsman found based on the available evidence, that the fusion procedure had been performed correctly and did not uphold this aspect of the complaint. However, he found that the Health Board failed to identify the non-fusion in a timely manner. He also found that Mr M was not advised to cease taking anti-inflammatory medication which was one of the factors which could have contributed to the non-fusion. The Ombudsman upheld these aspects of the complaint and recommended that the Health Board:

- a) apologise and provide Mr M with redress of £200 for the delay in identifying the non-fusion of the joint and £200 for the possibility that taking the anti-inflammatory might have contributed to the non-fusion; and
- b) that relevant staff be reminded about the significant features of this case and for staff to be mindful of the possible consequences of taking anti-inflammatory medication following such a procedure.

NOT UPHELD

Ynysawdre Community Council – Various other Case Number 201505371 – Report issued in November 2016

Mr G complained about the manner in which Ynysawdre Community Council ("the Council") had dealt with his complaint to it in July 2015. The complaint related to the responses received by Mr G to his information requests.

Following the involvement of the Ombudsman, the Council provided a written response to Mr G's complaint confirming that it had given Mr G all the information that it held. The Ombudsman found that the Council had not responded to Mr G's complaint in accordance with its published complaints procedure. However, the Ombudsman concluded that there had been no injustice caused to Mr G because he had always had the right to refer matters to the Information Commissioner if he was concerned that information was being withheld from him. The Ombudsman therefore did not uphold the complaint. The Council also offered to meet with Mr G to discuss any outstanding concerns with him.

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201603741 - Report issued in October 2016

Mr X complained about the length of time Betsi Cadwaladr University Health Board ("the Health Board") took to respond to his concerns of care and treatment provided to his late wife.

The Ombudsman contacted the Health Board and recommended that it undertake the following actions to resolve the complaint:

- a) provide an immediate update including an apology and explanation for its delays
- b) commit to issuing a response by 21 October 2016
- c) provide financial redress in the amount of £100 in recognition of the additional distress and time and trouble in pursuing this complaint.

The Health Board wrote to Mr X with its response and apologies and had agreed to provide him with the financial redress recommended.

Cardiff Council – Community Facilities, Recreation and Leisure Case Number 201602946 - Report issued in October 2016

Mr X complained about a number of arrangements that went wrong with the hire of a Cardiff Council (“the Council”) venue for his wedding. He also said that the Council’s response to his complaint about the matter was overly delayed and inadequate.

Mr X’s complaint about the wedding venue hire related to a private civil matter that fell outside of the Ombudsman’s jurisdiction. However, the Ombudsman contacted the Council to raise his concerns about its handling of Mr X’s complaint and to suggest the action that it might take to resolve the matter quickly. The Council agreed to:

- a) carry out an immediate investigation of Mr X’s complaint in accordance with the timescales set out in its Complaints Policy
- b) offer Mr X a redress payment of £250 in recognition of the poor handling of his complaint to date.

Cardiff and Vale University Health Board - Health Case Number 201603362 – Report issued in October 2016

Ms C complained that the Cardiff and Vale University Health Board (“the Health Board”) had failed to provide a timely response to the concerns she raised on behalf of her client. Ms C’s client’s husband passed away in November 2015 and she had concerns about his care and treatment.

Ms C wrote to the Health Board on 11 March, and her letter was not acknowledged until 21 March 2016. The Health Board issued holding letters on 28 April and 20 June which both stated the response would be issued within six weeks. However, no response was provided.

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

- a) apologise for the unacceptable delay and provide an explanation for it
- b) issue the full and final response within ten working days.

Vale of Glamorgan Council – Education Case Number 201603433 – Report issued in October 2016

Miss F complained that she was given incorrect information by Vale of Glamorgan Council (“the Council”)

regarding her application for a school placement. Miss F also complained that the Council had failed to respond to her email complaint or address her concerns.

The Ombudsman found that the Council addressed the substance of the complaint at the Appeal Hearing, and provided written response through that process. However, without a direct response to Miss F's email it seemed as though her complaint had been ignored.

The Council agreed to undertake the following actions by 4 November 2016, in settlement of the complaint:

- a) apologise for the failure to respond to the email directly
- b) provide a written corporate response to the complaint.

Hywel Dda University Health Board - Health Case Number 201603138 - Report issued in October 2016

Mrs X complained that Hywel Dda University Health Board ("the Health Board") failed to respond promptly to her complaint which was originally sent on 26 November 2015. Mrs X stated that the delay added to an already stressful situation.

The Health Board was contacted and agreed to provide the full response by 6 October 2016 and apologise for the delay.

Cwm Taf University Health Board - Health Case Number 201603228 – Report issued in November 2016

Ms H complained that she had raised concerns with Cwm Taf Health Board ("the Health Board"), which had not been answered. After chasing up her complaint, Ms H was advised that the response would be issued by 1 September 2016. However, it was not forthcoming by that date.

The Ombudsman found that Ms H had been waiting just over three months for a response to her complaint. However, the subject of the complaint was complex and required information from different departments to be collated and considered. Additionally, the complaint handler had a bereavement, which caused a slight delay.

The Ombudsman recommended, and the Health Board agreed that, the following actions should be undertaken in settlement of the complaint:

- a) contact Ms H directly to apologise for and explain the delay
- b) expedite and issue the response by the end of September.

NPT Homes – Housing Case Number 201603995 – Report issued in November 2016

Mr & Mrs A complained that NPT Homes ("the Housing Association") had failed to respond to a number of their letters and to carry out repairs to defective double-glazed windows in their home. Mr & Mrs A provided photocopies of proof of posting receipts for items of mail addressed to the Housing Association.

On receipt of the complaint, the Ombudsman contacted the Housing Association. It said that it had no record receiving Mr & Mrs A's letters however it agreed to investigate the matter further. The Housing Association also agreed to arrange for an inspection of Mr & Mrs A's windows and to arrange for any works as necessary.

A GP surgery in the Hywel Dda Health Board area – Health Case Number 201603637 – Report issued in November 2016

Mrs X complained that the Surgery failed to respond to her complaint. Mrs X was initially advised over the phone that a response was awaiting signature. Despite these assurances, the final response from the Surgery remains outstanding.

On receipt of the complaint, the Surgery was contacted and it agreed to provide a full response to Mrs X by 5 December 2016 in settlement of the complaint.

Wrexham County Borough Council – Roads and transport Case Number 201604469 – Report issued in November 2016

Mr A complained that the Wrexham County Borough Council ("the Council") had failed to reply to his two communications sent to it in July and August 2016. He also complained about two other matters that were not upheld.

The Ombudsman contacted the Council and it agreed to write to the complainant within 10 working days of the date of this summary outlining the actions it took to mitigate the risk of any further failures to reply to members of the public.

Abertawe Bro Morgannwg University Health Board – Health Case Number 201604526 – Report issued in November 2016

Mr X complained that Abertawe Bro Morgannwg University Health Board ("the Health Board") failed to adequately address his concerns regarding a GP Practice in the Health Board's area.

The Ombudsman considered that the Health Board had not clearly explained to Mr X the reasons it would not be investigating his concerns.

The Health Board agreed to complete the following actions by 30 November 2016 in settlement of Mr X's complaint:

- a) provide a written apology to Mr X for its handling of his complaint
- b) explain why it would not investigate Mr X's complaint
- c) provide a payment of £50 to Mr X for the time and trouble in making his complaint.

Cardiff Council – Roads and Transport Case Number 201604591 – Report issued in November 2016

Mr X complained about Cardiff Council's ("the Council") delays and communication issues in relation to a

liability claim.

While the Ombudsman cannot consider complaints about liability claims, in this instance it was clear that delays had been caused by Council departments before Mr X's claim was passed to claim handlers.

The Council agreed to complete the following actions by 30 November 2016 in settlement of Mr X's complaint:

- a) provide a written apology to Mr X for the delays and communication issues
- b) give Mr X an explanation for the delays
- c) provide a timescale to Mr X for the response to his claim.

Abertawe Bro Morgannwg University Health Board – Health Case Number 201603549 – Report issued in November 2016

Mr X complained that he had not received a response from his complaint letter to the Abertawe Bro Morgannwg University Health Board ("the Health Board") of 27 January 2016 about the care and treatment his partner, Ms Y, had received in relation to an admission to Morriston Hospital with gall bladder health problems in 2014.

The Ombudsman found that this was an unacceptable delay and made the following recommendations that the Health Board agreed to:

- a) provide an written apology to Mr X for the delay in providing a response to his complaint letter of 27 January 2016
- b) provide a full complaint response to Mr X by 1 December 2016
- c) provide clarification in the response about what aspects of Mr X's complaint have been investigated and why.

Betsi Cadwaladr University Health Board - Health Case Number 201603334 - Report issued in December 2016

Mr X complained that a clinical psychologist disclosed information about him to another agency, in breach of the confidence within which he had provided that information. He was also aggrieved about Betsi Cadwaladr University Health Board's ("the Health Board") handling of his complaint about the matter.

The complaint was settled and the investigation discontinued when the Health Board provided a substantive written response to Mr X's complaint; offered Mr X a meeting with the Head of Psychology Services and offered a payment of £300 to Mr X in recognition of the delay he had experienced in being provided with the second complaint response and in having the aforementioned meeting arranged.

Betsi Cadwaladr University Health Board - Health Case Number 201605398 - Report issued in December 2016

A North Wales Community Health Council advocate ("the advocate") made a complaint on behalf of Dr

A about Betsi Cadwaladr University Health Board's ("the Health Board") handling of Dr A's complaint regarding the care provided to her late mother, Mrs B.

The Health Board agreed to complete the following actions in settlement of the advocate's complaint:

- a) Issue its full and final response to Dr A's complaint by 13 January 2017
- b) Provide a written apology for the delay in responding to Dr A's complaint
- c) Offer a payment of £150 to Dr A for the time and trouble in making her complaint to the Ombudsman.

Betsi Cadwaladr University Health Board - Health Case Number 201604602 - Report issued in December 2016

Mr X complained about a range of issues regarding the Ophthalmology Department of a hospital in Betsi Cadwaladr University Health Board's ("the Health Board") area. Mr X also complained about the Health Board's handling of his complaint.

The Health Board agreed the following actions in settlement of Mr X's complaint:

- a) Provide a written apology to Mr X for the delay in responding to his complaint
- b) Explain the reasons for the delay to Mr X
- c) Issue its complaint response by 23 December 2016
- d) Offer a payment of £25 to Mr X for the time and trouble in making his complaint.

Cardiff Council – Complaints handling Case Number 201604495 - Report issued in December 2016

Mr S complained that he had been denied a landlord licence by Cardiff Council ("the Council") despite, he said, having accreditation as a landlord in England. The Council is the authority designated by Welsh Government to administer Rent Smart Wales (RSW) which oversees the licensing of landlords owning properties in Wales. Mr S was told by RSW that he was required to complete a further course, which he felt he should not need to do. To supplement his complaint, Mr S produced an email from the body representing landlords, primarily in England (the NLA), which stated that he was compliant with the law's requirements in Wales.

Having considered the evidence, the Ombudsman decided not to investigate the complaint as it was clear that Mr S had not produced evidence to satisfy the requirements set out by RSW. However, the information sent to Mr S by the NLA, which was an approved training provider for RSW, was misleading. On being contacted the NLA agreed it was an error to send it. In light of that, the Council told the Ombudsman that it would only take enforcement proceedings against a landlord, such as Mr S, if he was not taking steps to obtain a licence as soon as practicable.

It also offered a resolution by agreeing to offer Mr S free access to the RSW's online foundation course in order that Mr S could complete it to regularise his position as soon as possible.

Flintshire County Council – Planning and building control Case Number 201604925 - Report issued in December 2016

Mrs O complained that Flintshire County Council ("the Council") had failed to provide her with a response to her formal complaint. The initial matter was raised with the Council in April 2016. However, Mrs O raised further concerns with the response to that complaint in June 2016, which were not responded to. After allowing the Council a reasonable opportunity to exhaust its complaints procedure, Mrs O complained to the Ombudsman.

The Ombudsman found that the delay in providing Mrs O with a response was unacceptable. The Council issued a response to the complaint, and further agreed to complete the following actions in settlement of the complaint:

- a) apologise for the extensive delay
- b) offer £150 financial redress for Mrs O's time and trouble
- c) confirm that agreed actions had taken place
- d) complete all further actions within 14 days

Education

UPHELD

Ceredigion County Council – Special Educational Needs (SEN)

Case Number 201404146 – Report issued in October 2016

Mr A complained about several aspects of the way in which the Council, as Local Education Authority ("LEA") dealt with his family regarding the provision of services to meet the special educational needs of two of their children. The Ombudsman investigated those aspects of the complaint which related to the provision of Welsh education for the children, the removal of transport from the children's statements of special educational needs ("SSENs") and the involvement of the LEA in the Independent Reviewing Officer ("IRO") process/implementation of the IRO recommendations.

The Ombudsman found that the LEA had arranged for the school to provide Welsh education; however, although it was aware that difficulties had arisen, the LEA did not fulfil its duty to ensure the provision was made. This part of the complaint was upheld. The Ombudsman did not uphold the complaint in respect of transport or the IRO.

The Ombudsman recommended that the LEA apologise to Mr A, and develop a plan to make and deliver appropriate Welsh language provision for the children, having first ascertained their wishes in this respect.

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Bridgend County Borough Council – School transport

Case Number 201604023 – Report issued in November 2016

Mrs A complained that Bridgend County Borough Council ("the Council") failed to provide information requested in May 2016 to enable her to challenge the safe walking route to school aspect of its school transport policy. Mrs A said that the Council failed to adequately respond to her concerns and questions. As a consequence Mrs A said that her son's transition to comprehensive school was fraught with anxiety and worry. The Council's response to the complaint coincided with Mrs A's complaint to the Ombudsman. This confirmed that it needed to re-evaluate the route as part of the process.

Although the Ombudsman was satisfied that the Council's decision to re-evaluate the route was not unreasonable and that it provided some reassurance to Mrs A, he shared her concern that it did not sufficiently detail the current transport arrangements for her son and the actions being taken forward. The Ombudsman also expressed concern that Mrs A's complaints had not been considered under the corporate complaints process. The Council was therefore asked to:

- a) write to Mrs A to explain the current position with the transport arrangements and explain what actions it is taking going forward
- b) apologise to Mrs A for the delay in responding to her complaint and make a payment of £50 in recognition of the time and trouble taken in pursuing them.

Environment and Environmental Health

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Wrexham County Borough Council - Refuse collection

Case Number 201603984 – Report issued in October 2016

Mr A complained that Wrexham County Borough Council's ("the Council") bin wagon caused damaged to his lawn and the village green. He raised a complaint with the Council however it failed to respond.

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

- a) the appropriate person to contact Mr A and apologise for not dealing with the complaint appropriately
 - b) offer Mr A a payment of £25 for the delay in dealing with the complaint.
- Furthermore, the Council offered to reimburse Mr A for the costs of repairing the lawn as he had already tended to it himself.

Bridgend County Borough Council - Refuse collection, recycling and waste disposal

Case Number 201603775 - Report issued in October 2016

The complainant Ms S complained that Bridgend County Borough Council ("the Council") was not adequately dealing with a problem of refuse stored within a brick built storage area owned by Hafod Housing Association ("the Housing Association"). She stated that the Council's decision to move to fortnightly refuse collections had added significantly to the problem of vermin and undesirable smells from the refuse.

The Housing Association had considered the use of a large wheelie bin as an alternative, but, the Council sub contractors were unable to collect from this type of bin. It was discovered that the complainant was frustrated at having to deal with two separate bodies about her complaint.

The Council agreed to resolve the complaint by:

- a) meeting with the Housing Association on site and decide on a reasonable way forward
- b) ensuring that one of the bodies would appraise the tenants of its proposed actions.

This would be completed within 20 working days of the date of the Ombudsman's decision letter.

Caerphilly County Borough Council – Pollution and pollution control measures

Case Number 201604163 – Report issued in November 2016

Mr A complained that Caerphilly County Borough Council ("the Council") failed to take action in relation to bins being left outside his property by other residents.

It was established that Mr A initially raised concerns with the Council in November 2015. However after contacting the Council on several occasions, his communications were treated as a service request and were not escalated to a formal complaint for consideration.

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

- a) provide Mr A with an apology for not treating the correspondence as a complaint sooner
- b) offer a time and trouble payment of £50 for the inconvenience of having to raise a complaint with the Ombudsman
- c) provide a full response in line with the corporate complaints procedure.

Powys County Council – Flooding / flood damage

Case Number 201602884 - Report issued in December 2016

Mr G complained that Powys County Council (“the Council”) did not follow its complaints process and did not fully respond to the issues he raised as part of the complaints process. The Ombudsman found evidence that the Council had not followed its complaints procedure in this case and that it had not provided a full and proper response to the complaint.

In order to settle the complaint, the Council agreed to apologise to Mr G, undertake a thorough review the handling of this complaint, provide training to the staff involved on recognising and handling complaints and to undertake an investigation of Mr G’s outstanding concerns and provide him with a full response which sets out the Council’s position.

Cardiff Council – Refuse collection, recycling and waste disposal

Case Number 201604880 - Report issued in December 2016

Mr X complained that Cardiff Council (“the Council”) had failed to collect his refuse on a number of occasions resulting in him contacting the Council to arrange the collections himself. Mr X said that he complained to the Council on 30 September but, at the time of bringing his complaint to the Ombudsman he had not received a response.

Upon receipt of this complaint the Ombudsman’s office contacted the Council to discuss the complaint and make recommendations that would hopefully resolve the matters Mr X complained of. The Council agreed to provide a full response and provide a £50 monetary fee in recognition of the time and trouble taken for Mr X to pursue his complaint.

The Ombudsman understands that the Council has now issued its full response outlining what it believes had happened to result in missed collections and apologised for the inconvenience. It also explained the procedure it had put in place to stop it from occurring in the future.

Housing

NOT UPHELD

United Welsh Housing Association – Neighbour disputes and anti-social behaviour Case Number 201601298 – Report issued in November 2016

Ms X complained that United Welsh Housing Association ("the Housing Association") failed to take action in relation to her anti social behaviour complaints against her neighbour. Ms X said that she had suffered anti social behaviour for several years which culminated in police involvement in October 2015.

The Ombudsman found that the Housing Association acted reasonably in considering the anti social behaviour complaints. The Ombudsman was satisfied that the Housing Association took appropriate steps to resolve matters in accordance with its relevant policies and procedures. The Ombudsman concluded that the Housing Association's actions did not amount to maladministration. The complaint was not upheld.

EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

Bron Afon Community Housing Ltd - Repairs and maintenance Case Number 201501049 – Report issued in October 2016

Mrs A complained about the Authority's complaints handling and its failure to respond to her concerns.

The investigation revealed some concerns about the way the Authority handled Mrs A's complaint. The decision to discontinue Mrs A's complaint was based on the actions the Authority had already taken to address these concerns, and the further additional actions it agreed to take to avoid a recurrence of such events.

As such the investigation was discontinued on the basis of a voluntary settlement. The Authority agreed to provide Mrs A with an apology and financial redress for the shortcomings identified in its complaints handling. Further the Authority agreed to review its complaints policy and to provide training to its complaints handling staff, on its public sector duty.

Trivallis – Repairs and maintenance Case Number 201603473 - Report issued in October 2016

Mr X complained that Trivallis ("the Housing Association") took 18 months to find and repair a leak in his bathroom. Mr X also complained about the lack of communication received from the Housing Association.

The Ombudsman contacted the Housing Association, which agreed:

- a) to provide Mr X with a written apology, and
- b) to offer a financial payment in recognition of the time and trouble taken to pursue the complaint.

Newport City Homes – Neighbour disputes and antisocial behaviour

Case Number 201602777 - Report issued in October 2016

Ms X and Mr Y complained that Newport City Homes ("the Housing Association") had not followed their own policies and procedures in relation to taking action about the anti-social behaviour ('ASB') that they had reported. They further complained that they had not been offered support or been provided with advice about a priority move.

Whilst no failings were found in relation to action taken by the Housing Association in response to the reporting of the ASB, the Ombudsman found that there was opportunity to consider extra support and advice for the complainants. Therefore, NCH agreed to the following within one month of receipt of the decision letter:

- a) reconsider referring Ms X and Mr Y for further support – Victim Support and / or other appropriate referrals
- b) contact Ms X and Mr Y to provide the relevant advice required to apply for priority housing via Newport City Homes

Cardiff Council - Estate management and environment/common areas/hedges and fences etc.

Case Number 201603756 - Report issued in October 2016

Mr X complained that Cardiff Council ("the Council") had not addressed ongoing issues regarding waste collections. Mr X said that waste was not being collected due to overflowing and contamination which was being caused by neighbours.

The Council could not provide evidence to the Ombudsman that it had monitored collections at Mr X's property, and agreed the following actions in settlement of his complaint:

- a) provide a written apology to Mr X as the promised actions in its June complaint response have not remedied the ongoing issues
- b) offer £25 to Mr X for the time and trouble in making his complaint to the Ombudsman
- c) explain the actions it will now take to address the ongoing issues.

The Council agreed to complete the above actions by 28 October 2016.

Hafod Housing Association - Estate management and environment/common areas/hedges and fences etc

Case Number 201603006 - Report issued in October 2016

Ms S complained that Hafod Housing Association ("the Housing Association") failed to adequately deal with refuse storage issues for its tenants. The build up of refuse sacks in a brick built storage area outside her home was causing problems with vermin, flies and unpleasant smells. The build up of refuse was likely caused by the local council's decision to move from weekly to fortnightly collections.

The Housing Association agreed to:

- a) meet with the Council on site and agree a plan of action to deal with the issues raised in Ms S's

complaint

- b) to advise tenants in writing of the agreed actions resulting from the meeting.

This would be completed within 20 working days of the date of the Ombudsman's decision letter.

Newport City Homes – Repairs and maintenance

Case Number 201603621 - Report issued in October 2016

Mr F complained that his front door fell off its hinges in February and was not repaired for seven months. Mr F said that Newport City Homes ("the Housing Association") failed to ensure the new door had been ordered or maintain appropriate contact with him.

The Ombudsman found that whilst the new door had already been fitted, the Housing Association had misinformed Mr F and failed to act appropriately to ensure the new door was ordered and the damage repaired. He also found that the Housing Association missed opportunity to escalate the complaint once it had been made aware of the matter.

The Housing Association acknowledged the shortcomings in the way it handled the matter and agreed to complete the following actions within four weeks of the Ombudsman's decision letter:

- a) provide a full written apology to Mr F
- b) offer a sum of £150 financial redress for his time and trouble.

Trivallis – Neighbour disputes and antisocial behaviour

Case Number 201604018 - Report issued in October 2016

Ms A, a tenant of Trivallis ("the Housing Association"), complained that it had not responded or done enough about complaints of noise nuisance she had made about her neighbour (who was also a tenant of the Housing Association). The Housing Association had acknowledged communication failings, allocated a new housing officer to Ms A and offered some redress. It said there was insufficient evidence to warrant more action being taken against its tenant as was requested. Ms A was unhappy with the redress amount offered and lack of action against her neighbour. She had since made an application for an immediate transfer asking that the Housing Association exercise its management discretion to facilitate an early move.

The Ombudsman decided not to investigate the complaint in light of the failings already acknowledged and the limitations on his jurisdiction. He could not compel the Housing Association to take action against its tenant as it had assessed the evidence and felt it to be insufficient. It was a decision it was entitled to take. It was also its decision whether, or not, to exercise discretion for an early management transfer. The Ombudsman did however feel the following actions would be a more reasonable resolution of the complaint made to him. The Housing Association agreed that it would:

- a) apologise in writing again to Ms A for the communication failings identified
- b) offer her redress of £150 for the failings (in addition to the £20 voucher it had offered earlier)
- c) respond to any further incident in a timely and appropriate way

d) assess Ms A's transfer application in line with its policy and communicate the result of that assessment/decision to her.

Trivallis – Repairs and maintenance

Case Number 201603664 – Report issued in October 2016

Mr N, a tenant of Trivallis ("the Housing Association"), complained that when he moved in to his home repair works were needed at the property and that the Housing Association had taken too long to carry them out. In its own complaint response to Mr N, the Housing Association accepted that works were needed but said they had now been undertaken and offered Mr N a credit of two weeks rent to his account as compensation for his inconvenience.

The Ombudsman decided not to investigate the complaint in light of the works being completed and the Housing Association having responded to Mr N's concerns within a reasonable time. Furthermore, it was said that Mr N had been keen to move in to the property immediately before his landlords could complete pre letting work. The Ombudsman, however, felt that the following actions would be a reasonable resolution of the complaint made to him, in light of his not having powers to question or assess the quality of work carried out. The Housing Association agreed that it would:

- a) confirm satisfactory completion of the work (an inspection by a surveyor would facilitate this)
- b) pay the sum offered of £178.48 as a credit to Mr N's rent account
- c) apologise to Mr N and offer him further redress of £50 for his time and trouble (payable directly to him).

Pembrokeshire Housing Association Ltd & Mill Bay Homes Ltd - Other

Cases Number 201601724 & 201603330 – Report issued in October 2016

Mr A, an owner occupier, complained about both Pembrokeshire Housing Association ("the Housing Association") and Mill Bay Homes Ltd ("MBH"). He complained about a number of things that happened whilst MBH was developing land adjacent to his home, including that it had (he alleged) caused damage to his boundary wall whilst excavating, failed to construct in accordance with approved plans, and that MBH should have its status removed. Mr A also complained that MBH and the Association had failed to deal with his formal complaints about those issues when put to them.

Although a developer of properties, MBH, by virtue of its being a subsidiary of the Housing Association, is registered separately on the Welsh Government's maintained register of social landlords. Therefore, it falls within the Ombudsman's jurisdiction as a "public body" even though it provides no actual services to the public. The Ombudsman concluded that he could not deal with many of Mr A's complaints, as they were matters either outside his jurisdiction (MBH's status and private boundary matters) or for others to deal with (the Local Planning Authority in the case of not building in accordance with approved plans). However, complaints handling is both a service and an administrative function of a public body, so falling to the Ombudsman to consider.

The Ombudsman found that MBH had no proper policy in place for dealing with complaints from individuals, such as Mr A, who were not purchasers of its properties. This went against best practice for

public bodies. Whilst Mr A had asked the Housing Association to intervene it was not the body he had a dispute with and it was not providing any service for Mr A. It directed him to MBH. The Ombudsman, however, also noted that the Association's own complaints policy was misleading so far as his role was concerned.

The Ombudsman agreed with the Housing Association and MBH that they would resolve Mr A's complaints by undertaking the following actions:

- a) the Housing Association would review and amend its complaints policy
- b) MBH would apologise in writing to Mr A for the failure to have a formal complaints policy in place and the resulting failure to deal with his complaints
- c) MBH would offer Mr A redress of £75 for his consequent time and trouble in pursuing his complaints with the Ombudsman
- d) MBH would put in place a two-stage complaints policy, in line with the Model Complaints Policy approved by Welsh Government, after approval by its Board.

Cardiff Council - Repairs and maintenance

Case Number 201604031 – Report issued in November 2016

Mr O complained that Cardiff Council ("the Council") failed to carry out repairs to his garden fence panels within a reasonable timescale. Mr O purchased the materials required and completed the repairs himself. In doing so, Mr O incurred losses in the sum of £148.12 which he sought to recover from the Council.

The Ombudsman found that Mr O had made reasonable attempts to notify the Council of the repairs required, but the Council had failed to confirm whether or not such repairs would be carried out.

The Council agreed to undertake the following actions:

- a) offer an apology to Mr O for the inconvenience caused to him in pursuing matters
- b) issue a cheque in the sum of £148.12 in recognition of the costs incurred in pursuing the matter by 23 December 2016.

Pembrokeshire Housing Association Ltd - Other

Case Number 201604686 – Report issued in November 2016

Ms S complained that Pembrokeshire Housing Association Ltd ("the Housing Association") had failed to adequately deal with a leak that occurred at her home. There was significant damage and the Housing Association failed to find her suitable alternative accommodation until approximately three weeks after the incident.

There were other matters complained of that fell outside the Ombudsman's jurisdiction.

The Housing Association agreed to:

- a) write a letter of apology to Ms S
- b) offer ex gratia payment of £350 for time and trouble taken to make her complaint.

Trivallis – Repairs and maintenance

Case Number 201604932 - Report issued in December 2016

Ms X complained about a range of issues regarding overdue repairs to her property, in particular the installation of a ramp which was not sufficiently flat for a mobility scooter.

The Ombudsman found that Trivallis had completed the majority of repairs since Ms X's complaint was made.

Trivallis agreed to complete the following actions in settlement of Ms X's complaint:

- a) Complete overdue works by 7 December 2016
- b) Offer a goodwill payment of £20 towards the cost of taxis which Ms X has incurred due to being unable to use her mobility scooter, pending proper completion of the ramp.

Wrexham County Borough Council – Applications, allocations, transfers and exchanges

Case Number 201604453 - Report issued in December 2016

Ms G complained to Wrexham County Borough Council ("the Council") about the way she had been dealt with over a period of 12 months in relation to complaints she had made about her neighbours and her attempts to be re-housed. Ms G was also unhappy at the Council's complaint response and a number of points it raised which Ms G said were incorrect.

The Ombudsman assessed Ms G's complaint, and whilst he concluded that the majority of her concerns would not be investigated due to issues of proportionality, the Council agreed to take the following action to resolve one element of the complaint:

- a) Write to Ms G clarifying the content of its complaint response letter and offering a full apology.

Planning and Building Control

UPHELD

Cardiff Council – Rights of way and public footpaths

Case Number 201503337 - Report issued in November 2016

Mr D complained that the decision taken by Cardiff Council ("the Council") to re designate pavements in the vicinity of his home as shared-use pedestrian/cycle ways was inappropriate for the location in question and failed to take account of his concerns about safety. Mr D also complained that an Experimental Traffic Regulation Order (ETRO) that was implemented by the Council to assess the impact of cyclists using the footways and pavements was incorrectly administered.

Mr D additionally complained that numerous letters that he sent to the Council were not responded to, or he had received delayed responses.

The Ombudsman did not uphold Mr D's complaint that his concerns about safety were not taken into account or that the ETRO was improperly administered. However, the Ombudsman did uphold Mr D's complaint that letters that he sent to the Council were not responded to or received delayed responses.

The Ombudsman recommended that the Council should apologise to Mr D and make a payment to him of £150 in recognition of the correspondence and complaint handling failings identified in this report.

The Council accepted the report's findings and recommendations.

EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

Powys County Council – Handling of Planning Application

Case Number 201602815 – Report issued in October 2016

Mrs A complained that Powys County Council ("the Council") did not follow the Environment Impact Assessment ("EIA") Regulations in respect of pre commencement decisions for two wind farm developments in her local area. As a consequence of this Mrs A said that she had been deprived of the right to challenge the applications. The majority of Mrs A's concerns were upheld by the Council however she was not satisfied with the actions taken in response to the failings identified.

Whilst the Ombudsman was satisfied that Mrs A's concerns were appropriately addressed in the complaint response and that the recommendations made by the Council were reasonable it was felt that there was an absence of a defined action plan demonstrating commitment to them.

Consequently the Council agreed to take the following actions within one month:

- a) create an action plan defining what actions will be taken, by whom and a date for review/ completion
- b) ensure that planning officers are reminded of the training on Scoping.

Roads and Transport

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Vale of Glamorgan Council - Parking

Case Number 201604248 – Report issued in November 2016

Miss A complained to the Ombudsman about Vale of Glamorgan Council's ("the Council") administration of her application for a Blue Badge. Miss A complained that the Council did not explain the reasons why she did not meet the eligibility criteria when the application was refused. Miss A also complained that the Council did not provide her with any information about what to do next.

Having discussed the complaint with the Council it agreed to the Ombudsman's recommendations:

- a) reconsider Miss A's eligibility for a Blue Badge based on the information already have provided
- b) if Miss A's application is declined, provide an explanation of the specific reasons why the eligibility criteria was not met as laid down in legislation
- c) if Miss A's application is declined explain the next steps to take if the condition deteriorates rapidly or the ability to walk gets worse, or where a new disability occurs
- d) explain what internal review/complaint procedures are available to Miss A, and
- e) pay Miss A the sum of £150 for the inadequacy of the Council's response to the Blue Badge application

In addition to the above action the Council has said it will review its processes for the Blue Badge scheme and make any necessary amendments.

Newport City Council - Parking

Case Number 201603611 – Report issued in November 2016

Dr H complained that Newport City Council ("the Council") did not provide him with a residential parking permit for use outside his rented property while allocated to work for the NHS in Newport. Dr H said that as he was a resident and the owner of the car and therefore met the minimum requirements to be provided with a parking permit. However, the Council refused his application on the basis that his car was still registered to his permanent residence in Birmingham.

The Ombudsman found that whilst the Council was entitled to make this decision, the policy had been applied to rigidly in this case, considering Dr H's circumstances.

The Council agreed to reconsider and revise its decision, and provided Dr H with a parking permit, on receipt of the appropriate fee and evidence of residency and ownership of the car.

Social services - Adult

UPHELD

Carmarthenshire County Council - Services for People with a Disability Case Number 201503417 – Report issued in October 2016

Mr and Mrs A complained that:

- There was a four week delay in Carmarthenshire County Council (“the Council”) providing appropriate hoist-slings for their severely disabled daughter, Ms B. This delay meant that Ms B was, for this period, dependent on being manually lifted.
- When the slings were provided they were of a size and type suitable for children rather than adults. Ms B sustained bruising as a result of the slings being unsuitable. This gave rise to a Safeguarding investigation which delayed Mr and Mrs A’s Stage 2 complaint to the Council being investigated and determined.
- Ms B was unable to attend day services and respite care as a consequence of these problems.
- The Council failed to take decisive action to expedite a solution to the family’s difficulties.

The Ombudsman found that there was a four week delay in the Council providing the slings specified in Ms B’s manual handling plan. As such, the Council failed to fully meet one of Ms B’s assessed needs. Whilst the Ombudsman upheld this complaint, he considered that, in view of the exceptional circumstances that gave rise to the problem, together with the fact that the Council made every reasonable effort to resolve the situation, and given that the family had received an apology from the Council, it was not appropriate to recommend any further action. The Ombudsman did not uphold the family’s other complaints.

Betsi Cadwaladr University Health Board & Flintshire County Council Case Numbers 201502879 & 201503954 - Report issued in November 2016

Mr X complained that allegations of inappropriate behaviour by him towards his carers were not put to him to respond to and were not properly investigated. Mr X also complained he had been denied the option of arranging his own carers using Direct Payments and had been left without carers for two years. Finally, Mr X complained that there were disproportionate delays in handling his complaint.

The Ombudsman found that the allegations had not been handled or investigated appropriately. He also found that Mr X’s request for Direct Payments had not been appropriately considered. The Ombudsman concluded that Mr X had been avoidably left without care input for two years and that the Health Board and Council had failed to make an appropriate offer of care. Finally, he found that complaint handling had been poor and disproportionately delayed.

The Ombudsman recommended:

- a) procedural changes in relation to the handling of such allegations
- b) a reconsideration of Mr X’s needs and how these would be met

- c) that apologies should be made; and
- d) that the Health Board and Council should pay Mr X redress in the sum of £2300 and £1450 respectively, in recognition of the shortcomings identified.

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Flintshire County Council – Services for Older People Case Number 201604772 – Report issued in November 2016

Ms S complained that she had not received an acknowledgement or response to her letter, and had not been given any update on the investigation into the concerns she had raised.

The Ombudsman found that Flintshire County Council (“the Council”) intended to provide a full response once the investigation was complete; however it had not kept Ms S informed of its intentions.

The Council agreed to provide Ms S with an update on the investigation following the final meeting, and to provide a full response to her letter of 18 October as soon as possible and no later than 18 November 2016.

Neath Port Talbot County Borough Council – Services for older people Case Number 201604752 – Report issued in November 2016

Mr X complained that an investigation undertaken by Neath Port Talbot County Borough Council (“the Council”) was not sufficiently thorough.

The Ombudsman found that the Council were in the process of arranging a case conference meeting with Mr X and, therefore, the complaint was premature for consideration by his office.

The Council agreed to:

- a) expedite arranging the case conference meeting with Mr X
- b) provide a written response to Mr X following the meeting if he remained dissatisfied

If Mr X was not willing to attend a meeting, it would provide a written response to the complaint on the basis of the information Mr X had provided to the Ombudsman.

Neath Port Talbot County Borough Council – Services for vulnerable adults Case Number 201604986 - Report issued in December 2016

Mrs X complained on behalf of Mr Y that a complaint made to Neath Port Talbot County Borough Council (“the Council”) had not been adequately dealt with at Stage 2 and they were still awaiting the arrangement of a meeting.

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

- a) A written apology for the delay in arranging the meeting requested
- b) An explanation for the delay
- c) Expedite arranging the meeting between the Council and the complainants.

Gwynedd Council - Other

Case Number 201605376 – Report issued in December 2016

Mr X complained that he had been given incorrect information from Gwynedd Council (“the Council”) regarding the date from which interest charges would be accrued. He said he was advised that if the charges for his late mothers’ house were repaid within six months from the date of her passing he would not pay any interest and that the interest would accrue after the six months, that is August 2016. When the six months had elapsed he had received a bill from the Council which included payable interest from February 2016.

Mr X submitted a formal complaint to the Council and received a Stage 1 response letter dated 10 October. Mr X was dissatisfied with its response and wrote to it on 17 October and asked it to look at the matter again. However, the Council failed to escalate the complaint appropriately and, therefore, no Stage 2 investigation was conducted.

The Ombudsman contacted the Council to request that it escalated this complaint appropriately and respond to Mr X directly which it agreed to do. It is the Ombudsman’s understanding that a Stage 2 investigation has commenced.

Social services - Children

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

Bridgend County Borough Council – Children's Social Services (Other)

Case number 201503185 - Report issued in November 2016

Mr N was a looked after child with Bridgend County Borough Council ("the Council") and placed with his former foster carers Mr and Mrs A when he was a toddler. The placement lasted many years but broke down in 2014. Mr N subsequently approached the Council to obtain further information about savings that Mr and Mrs A had made on his behalf. Mr N complained that:

- the Council had not managed his savings properly and in accordance with its policy
- some of his savings were used, without consultation with him, to pay for trips for which he should have received a special allowance
- the savings he received in January 2015 were substantially less than he believed they should have been.

The Ombudsman's investigation related to the actions of the Council and not the foster carers. He found evidence that the Council was inconsistent and contradictory in the way it applied its internal guidance for foster carers in its Fostering Handbook. Some of its guidance it enforced whilst others, like saving for looked after children, it did not. This was despite regulatory guidance that foster carers are expected, amongst other matters, to operate within the guidance set out in the Fostering Handbook.

As a corporate parent for a looked after child, a council has a duty to ensure that there is adequate oversight and monitoring of savings that are made on behalf of the looked after child/ren ("LAC"). However, in Mr N's case the Ombudsman found the Council's monitoring of his savings both intermittent and inadequate. He concluded that these administrative failings amounted to maladministration and upheld this aspect of Mr N's complaint.

The Council was unable to provide evidence to show that Mr N was consulted or agreed to the use of his savings to pay for two trips which cost in total £1100. The Council agreed to fund one of the trips at a LAC review meeting in 2014, but later changed its view without notifying the Chair of the review meeting. Once again the Ombudsman found evidence of maladministration and upheld this element of Mr N's complaint.

In relation to the third element of Mr N's complaint, as the Council had failed to keep adequate records or retain his saving books at the end of his fostering placement, it was unclear why Mr N's savings were as low as they were. The Ombudsman determined that the failings that led to this position amounted to maladministration and upheld this aspect of Mr N's complaint.

He reached the view that as a result of the Council's maladministration, it could not properly account to Mr N for his savings which caused him an injustice. He calculated a figure for appropriate recompense for Mr N. The Council challenged the figure arrived at, on the grounds that Mr N would have agreed other expenditure from his savings, without evidence that this was the case. The Ombudsman has been minded therefore to give the benefit of the doubt to Mr N, the more vulnerable party.

Mr N's case raises important issues about LAC and their savings at a local, regional and national level. It is therefore the Ombudsman's intention to share his report with Welsh Government.

He has made the following recommendations:

- a) The Council's Chief Executive should apologise in writing to Mr N.
- b) The Council should make a payment to Mr N of £3,310.
- c) The Council should make a payment to Mr N of £250 to reflect shortcomings in complaint handling.
- d) The Council should review this case from a complaint handling perspective and share with this office any lessons learned.
- e) The Council should share a copy of this report with its Corporate Parent Cabinet Committee and its Chair should provide this office with details of any actions this Committee intends to take as a result of this case.
- f) The Corporate Parent Cabinet Committee should consider the arrangements it deems most appropriate in respect of long term savings for LAC while encouraging them to save from pocket money. In doing so, the Council should have regard to the following: its duty to act as a corporate parent to give LAC the best possible start in life and other local authority saving schemes.
- g) The Council should provide this office with its proposals and action plan for reviewing cases of a LAC, who like Mr N, may be similarly affected in this regard.
- h) The Council should review its current arrangements/requirements in respect of savings and expenditure and the checking, retention and passing on of savings records at the end of a placement with a view to introducing clearer guidance/requirements.
- i) In collaboration with the Care and Social Services Inspectorate Wales the Council should revise its foster carer agreement to ensure that it is compliant with the requirements of Schedule 5 to the Fostering Services (Wales) Regulations 2003.

The Council agreed to implement all of the recommendations with the exception of recommendation (b), the payment to Mr N. It was prepared to reimburse Mr N for the two trips which were funded from his savings.

It is very disappointing that the Council has to date refused to accept these recommendations in full. If the Council maintains this position and fails to comply with recommendation (b) in full within two months of this report (i.e. by 21 January 2017), the Ombudsman will have to consider whether to issue a further special report against the Council under s22 of the Public Services Ombudsman (Wales) Act 2005. Should this continue to be the decision of the Council following the Corporate Parent Cabinet Committee's consideration of this report, in view of the seriousness of a s22 special report, he has recommended that this report is also shared with all of the elected members of the Council.

OTHER REPORTS - NOT UPHELD

Carmarthenshire County Council - Other

Case Number 201504009 - Report issued in December 2016

Ms A complained that although she believed that she was entitled to receive a fostering allowance for looking after her granddaughter, Child B, the payments had not been forthcoming from Carmarthenshire County Council ("the Council"). In setting out her reasons Ms A said that the Council had asked her to look after Child B.

The Ombudsman concluded that, based on the evidence considered, the arrangement by which Child B came to live with Ms A was a voluntary family arrangement and there was no indication that the Council had considered more formal child protection measures. The Ombudsman did not uphold Ms A's complaint.

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Cardiff Council - Other

Case Number 201603632 – Report issued in October 2016

Mrs P complained about the handling of her complaint regarding the actions of Social Workers in Children's Services at Cardiff Council ("the Council"). Mrs P said that the response was "lackadaisical" and did not explain the Council's reasons for its decisions and the recommendations it made to Family Court. Mrs P felt that her evidence had been ignored and disbelieved, and questioned the independence of the investigation. The Ombudsman found that the Council may have missed an opportunity to escalate the complaint appropriately, and considered it would be appropriate for the Council to consider both the substantive matters of the complaint and the handling of it.

The Council agreed to:

- a) undertake a full investigation, and
- b) provide Mrs P with a Stage 2 response within four weeks.

Gwynedd Council – Other

Case Number 201604679 – Report issued in December 2016

Mr A complained Gwynedd Council ("the Council") had refused to escalate his complaint concerning the level of service provided to his son, to Stage 2 of the Social Services Complaints Procedure ("the Procedure").

The Ombudsman noted there had been lengthy discussions between the Council and Mr A regarding his desired outcome that disciplinary action be taken against members of staff. Whilst this outcome could not be achieved by a Stage 2 investigation, in light of the concerns raised, the Ombudsman concluded it was in the best interests of Mr A's son to resolve the complaint. The Ombudsman noted that a Stage 2 investigation may result in alternative recommendations being made. Also, in accordance with the Procedure, Mr A had the right to ask for formal investigation of his complaint, particularly as he remained dissatisfied at the end of the Local Resolution Stage. The Ombudsman concluded there was no reason to suggest that the complaint could not be escalated.

The Council agreed to escalate Mr A's complaint to Stage 2 of the Procedure in settlement of the complaint.

Various - other

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Newport City Council - Other

Case Number 201506404 - Report issued in November 2016

Mr X complained that Newport City Council ("the Council") had not included his objection to an application for an alcohol licence in documents provided to the Licensing Panel. Mr X said a Councillor supported the application. Mr X said that subsequently a fee would be required to consider his appeal against the decision to approve the application. Mr X also complained about the Council's handling of his complaint.

The Council said that Mr X's objections had been referred to at the Hearing and considered by the Panel. The Council explained that the Councillor had followed the Members Code of Conduct. The Council said that the fees are set by the Magistrates Court which it does not administer. The Council apologised to Mr X for its complaint handling and made a payment of £50 for his time and trouble in pursuing the complaint. It was considered that the substance of Mr X's complaint had been resolved.

Monmouthshire County Council - Poor / No communication or failure to provide information

Case Number 201604357 – Report issued in November 2016

Mr & Mrs X's complaint related to Monmouthshire County Council's ("the Council") failure to carry out repair work on drainage pipes. This was in order to prevent further flooding incidents at their property.

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

- a) works to commence the week beginning 14 November 2016 (weather permitting).

Betsi Cadwaladr University Health Board - Poor/No communication or failure to provide information

Case Number 201604771 – Report issued in November 2016

Mr X complained about changes that have been made to the shift patterns of district nurses. Mr X also complained that Betsi Cadwaladr University Health Board ("the Health Board") had failed to provide an appropriate response to his complaint.

The Ombudsman did not consider the substantive issue of Mr X's complaint as it was an employment-related matter and fell outside of his jurisdiction.

The Health Board agreed to complete the following actions in settlement of Mr X's complaint:

- a) provide a written response to Mr X's complaint by 23 December 2016
- b) expedite arranging the meeting Mr X requested with staff members.

Flintshire County Council – Other miscellaneous

Case Number 201604247 – Report issued in November 2016

Ms X complained on behalf of her sisters that Flintshire County Council ("the Council") had not made comprehensive efforts to attempt to contact them to inform them of their father's death before carrying out a Public Health funeral. Further to this, she complained about the lack of communication from the Council in relation to valuable belongings that had been left in the property.

The Ombudsman did not find that there was any outstanding injustice in regard to the valuables removed from the property as they had now been returned to Ms X and her family. However, he did find inaccuracies in the investigation paperwork completed by the Council and indications that a more robust and relevant search of the property may have led to the retrieval of the daughters' contact details. In recognition of this the Ombudsman recommended the following settlement, which the Council have agreed to undertake within one month of receipt of the decision letter:

- a) provide an apology to the complainant for the handling of the investigation
- b) provide a redress payment of £250 to the complainant to reflect the time and trouble taken in making the complaint to the Council and in approaching this office
- c) provide evidence to the Ombudsman of reflection of this complaint within the service and consideration of additional procedural documents that would prevent such a complaint from arising in future.

More information

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

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

Public Services Ombudsman for Wales
1 Ffordd yr Hen Gae
Pencoed
CF35 5LJ

Tel: 0300 790 0203
Fax: 01656 641199
e-mail: ask@ombudsman-wales.org.uk (general enquiries)

Follow us on Twitter: [@OmbudsmanWales](https://twitter.com/OmbudsmanWales)

Further information about the service offered by the Public Services Ombudsman for Wales can also be found at www.ombudsman-wales.org.uk