Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

The Ombudsman's Casebook

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Contents

Health 2
Community Facilities, Recreation and Leisure 28
Complaints Handling 28
Environment and Environmental Health 31
Housing 31
NHS Independent Provider 33
Planning and Building Control 34
Roads and Transport 34
Social Services – Adult 35
Various Other 36

Health

Upheld

Hywel Dda University Health Board – Other
Case Number: 201804936 – Report issued in April 2020

Mr A complained about the cardiac rehabilitation service he received from Hywel Dda University Health Board ("the Health Board), which he said resulted in an injury to his chest. Mr A had some months earlier undergone heart by-pass surgery. In particular, he complained about the care and treatment provided in relation to the cardiac rehabilitation ("CR") sessions in February and March 2017 during which the injury happened. Mr A said that this directly resulted in his chest wound re-opening, which could not be re-wired. He has needed to wear a brace since. He also complained about the Health Board's handling of his complaint.

The investigation found that whilst it had been appropriate for Mr A to commence cardiac rehabilitation, the Health Board's lack of record keeping regarding the rehabilitation sessions was extremely concerning and amounted to maladministration. The lack of records provided no basis for CR patients to undertake rehabilitation exercises safely. In the absence of records to the contrary, the investigation found Mr A's account of how he sustained the injury to his chest, sufficiently plausible. The injury has left Mr A with symptoms that have an ongoing impact on his quality of life. The investigation also found maladministration in the way that the Health Board handled his complaint. The Ombudsman upheld Mr A's complaint.

The Ombudsman recommended that the Health Board should, within 1 month, issue an apology to Mr A for the failings identified in the report and redress of £250 for the poor complaint handling. He also recommended that within 1 month the Health Board carry out a review of how CR is provided, and, within 3 months, produce formal documentation to record assessments, the handover and monitoring of patients undertaking rehabilitation exercise, along with clear written information for patients.

Hywel Dda University Health Board – Clinical treatment in hospital
Case Number: 201807683 – Report issued in April 2020

Mrs A complained about her late husband's management and care by Hywel Dda University Health Board's ("the Health Board's) Glangwili General Hospital. Mr A, who suffered from rheumatoid arthritis, had started taking the immunosuppressant drug methotrexate, for the condition. Mr A was admitted to the Hospital in November and died from methotrexate-induced pneumonitis (a life threatening lung disease which is a rare complication of methotrexate) in January 2018. Mrs A was concerned that lessons had not been learnt from her husband's case. She was also dissatisfied with the Health Board's handling of her complaint and the robustness of its complaint response which was also made on behalf of the GP Practice.

The Ombudsman found that Mr A's respiratory management and care during his inpatient admission was appropriate and reasonable. He did not uphold this aspect of Mrs A's complaint.

Administratively, the Ombudsman found failings around the Health Board's complaint handling process. These related to delay and the robustness of the investigation which extended to learning lessons. As these failings caused Mrs A an injustice, the Ombudsman upheld this part of her complaint.

The Ombudsman recommended that given Mr A's case, the Health Board should improve its consenting process when its rheumatology department prescribed methotrexate. Additionally, the Clinical Director for Primary Care should write to GP Practices in the Health Board's area setting out the risks, although rare, of methotrexate-induced pneumonitis, and using Mr A's case as an example.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201806841 – Report issued in April 2020

Mr and Mrs X complained that on 7 December 2017, when their late mother ("Mrs Y") was taken to Glan Clwyd Hospital ("the Hospital") by ambulance, she did not receive appropriate treatment and should not have been discharged.

The Ombudsman found that Mrs Y was examined, diagnosed with a chest infection, and was prescribed appropriate antibiotics. However, the Ombudsman found that Mrs Y should have been admitted to the Hospital on that day in order to receive appropriate treatment. Mrs Y was discharged to her care home and sadly died of pneumonia at the Hospital a week later.

Whilst it would not be possible to say whether the sad outcome would have been different had Mrs Y been admitted to the Hospital on 7 December 2017, the Ombudsman found that any chance of Mrs Y receiving the appropriate care and potentially surviving the pneumonia was removed due the failure to admit her to the Hospital. The complaint was therefore **upheld**.

Betsi Cadwaladr University Health Board agreed to apologise for this failing to Mr and Mrs X within 6 weeks, to share the Ombudsman's report with relevant staff within 9 months, and to provide appropriate training to relevant staff within 12 months of the Ombudsman's report.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201900775 – Report issued in April 2020

Mrs X complained about the treatment her late mother Mrs Y, received from Betsi Cadwaladr University Health Board ("the Health Board"). Mrs X said that there was a failure to have identified a fracture and manage the associated pain. She complained about the appropriateness of a liver biopsy and said the risks were not fully explained. She complained there was a failure to diagnose metastatic disease and communicate this to Mrs Y in a timely manner. In addition, that there was a failure to manage Mrs X's pain after admission on 20 April 2018. Mrs X complained about discussions held around discharge.

The Ombudsman found there was a failure to identify two fractures however, it had not caused Mrs Y physical harm therefore this aspect of the complaint was not upheld. It was appropriate to have performed the liver biopsy, but there had been a failure to record discussions about the associated risks, this aspect of the complaint was upheld. He found that the metastatic diagnosis could not have been made sooner, but could have been communicated two days earlier however the delay allowed a support network to be in place which was appropriate, therefore this aspect of the complaint was not upheld.

The Ombudsman was unable to determine whether there was a failure to manage Mrs Y's pain due to the disparity between Mrs X's description and the clinical records. The Ombudsman found that it was appropriate to consider discharge options at an early stage and therefore this aspect of the complaint was not upheld. The Health Board agreed to the Ombudsman's recommendations to apologise to Mrs X and issue a reminder to all staff involved in surgical procedures of the importance of documenting discussions about consent in advance of a procedure.

Cardiff and Vale University Health Board - Clinical treatment in hospital
Case Number: 201807094 – Report issued in April 2020

Mrs B complained about the care her husband, Mr B, received from the Health Board, when he was admitted with a fast and irregular heart beat and swollen legs between 22 February and 14 June 2018. She said that Mr B's symptoms were caused by medication toxicity. Mrs B also complained that Mr B did not receive appropriate care for his diabetes, a rash and his physiotherapy needs. She also said that the Health Board failed to communicate with her effectively and appropriately.

The Ombudsman found that the Health Board made appropriate changes to Mr B's medication to carefully manage his symptoms, which were recognisable symptoms of his condition. There was no evidence Mr B suffered from toxicity as a result of his prescribed medication. He found that overall, the plan of care was, and remained, suitable to meet Mr B's diabetic needs; his medication was adjusted according to his blood sugar levels to reduce any adverse effects and he did not experience any diabetic emergencies. The Ombudsman also found that the care provided to Mr B for his rash fell within the bounds of reasonable clinical practice, and that the physiotherapy delivered was adequate and responsive to Mr B's needs and abilities, once Mr B was well enough to engage with it.

However, the evidence did not support that the level of communication with Mrs B by the Physiotherapy Team was entirely adequate and there were delays obtaining a review from Dermatology and the results of a skin biopsy. The Health Board agreed that the Physiotherapy Team would consider how to improve communication with patients' relatives, and to take action to identify and address any shortcomings in the referral process for Dermatology, as well as any shortcomings in the processing of biopsies and the timely availability of results.

Cwm Taf Morgannwg University Health Board - Clinical treatment in hospital
Case Number: 201807863 – Report issued in April 2020

Ms D complained about the care and treatment she received from a Consultant Orthopaedic Surgeon ("the Consultant") at an outpatient appointment at Ysbyty Cwm Cynon on 6 November 2018. Specifically, Ms D complained that:

1. The Consultant failed to adequately review and assess her conditions of chronic Osteochondral Defect ("OCD" – an ankle joint injury), Anterior Talofibular Ligament injury ("ATFL" – a tear in a ligament of the ankle) and arthritis, and improperly concluded that her conditions could not be helped by surgical intervention.
2. The Consultant declined her request to be referred for scans of her neck, back, pelvis and right lower leg.
3. During the consultation, the Consultant's attitude was intimidating and hostile and she was predisposed to discharge Ms D on the basis that her medical records indicated that the Health Board considered her to be "violent and aggressive".
4. The content and tone of the Consultant's follow-up letter to her GP unfairly suggested that her history of presentations and referrals to a range of medical specialists reflected her psychological ill-health rather than any underlying physical pathology.

The Ombudsman found that the review and assessment of Ms D's ankle conditions were clinically satisfactory and that it would not have been appropriate for the Consultant to have referred her for additional scans of her neck, back, pelvis and right lower leg as this was not the basis of the referral and appointment. The Ombudsman found no objective evidence that the Consultant's manner was hostile or that she was influenced by the violent/aggressive marker warning that had been placed in Ms D's medical records. However, the Ombudsman upheld the complaint that the Consultant's follow-up letter to her GP unfairly suggested that Ms D's history of presentations and referrals to a range of medical specialists reflected her psychological ill-health, rather than any underlying physical pathology. This view failed to take into account the physical conditions that Ms D had been diagnosed with. Whilst there was no

evidence to suggest that this was calculated to be offensive, the wording of the letter was open to this interpretation and so might have influenced any future medical consultation. This was an injustice to Ms D.

The Ombudsman recommended that the Health Board provides Ms D with a written apology for the way in which the Discharge Letter was composed and that it should make a payment to her of £250 in recognition of the avoidable inconvenience to which she was put in pursuing her complaint about this matter.

The Ombudsman also recommended that the Health Board confirms to his office that this report has been shared with and reflected upon by the Consultant (and Clinical Director) and that the Consultant has been reminded of the need for accuracy and the exercise of caution in preparing clinical/discharge letters that will be shared with patients.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201806437 – Report issued in April 2020

Mrs X complained that Betsi Cadwaladr University Health Board ("the Health Board") did not prescribe or administer Pro Re Nata ("PRN") or "as needed" medication to her husband Mr X, in a reasonable manner, and that the records of the medication given to Mr X were confusing and incomplete.

The investigation found that although the guidance on the use of PRN medication could have been clearer, generally there was evidence that the medication was prescribed appropriately and reasonably to control the distressing symptoms Mr X experienced. Although there were a handful of occasions where the Health Board did not follow appropriate practice, these were swiftly identified and stopped as a result of regular medication reviews.

In relation to the second part of the complaint, the investigation found that the Health Board failed to properly record the rationale for all uses of PRN lorazepam administered to Mr X, which caused an injustice to Mrs X who would not be able to find out the reasons why lorazepam was administered. The complaint was upheld on this basis.

The Ombudsman recommended that the Health Board apologise to Mrs X for this failing within one month. The Ombudsman noted that usually, he would recommend that the Health Board undertake staff training in relation to record keeping, however the ward where Mr X had been cared for had been closed some time ago, therefore this was not appropriate.

Cardiff and Vale University Health Board - Clinical treatment in hospital
Case Number: 201806053 – Report issued in April 2020

Mr A complained about the care and treatment his late wife, Mrs A, received from the Health Board during her admission to hospital. Mr A said that there was a failure to adequately monitor Mrs A; to keep accurate records and adequately communicate with her and the family and to fully address his complaint.

The investigation found that the care and treatment Mrs A received in hospital had been appropriate and that she had been adequately monitored. However, the investigation found that communication with Mrs A and her family and the associated record keeping had been poor. It was not clear from the records that Mrs A was provided with enough information to make an informed decision about aspects of her surgery. Additionally, the investigation found that there were significant and unexplained errors in the record of the post-mortem examination. Finally, the investigation found that there had been a failure to fully address Mr A's complaint. It was noted that, despite having been given a list of Mr A's questions in advance of a meeting, the attendees had failed to prepare for the meeting and could not answer the questions. Then, having agreed to respond and follow up on a number of points, the Health Board failed

to do so. The complaint was partly upheld.

It was recommended that the Health Board apologises to Mr A and his family; reminds the relevant clinicians of the need to ensure that conversations with a patient or family member are fully documented; ensures the Cardiac Surgery Department reviews its standards of consent against national guidelines; reviews whether the levels of supervision for non-consultant pathologists is adequate and identifies whether there are any barriers to liaison between the Pathologists and other hospital teams.

Hywel Dda University Health Board - Clinical treatment in hospital
Case Number: 201803909 – Report issued in April 2020

Ms B complained that her father Mr C, received inappropriate care and treatment as an inpatient in hospital from January to May 2016. Specifically, that as a stroke victim, Mr C did not receive enough consistent physiotherapy and was discharged prematurely from speech and language therapy. Furthermore, that there was miscommunication amongst staff about Mr C's diet and inadequate assessment of his abilities. Finally, that Mr C was administered unnecessary medication and he was inappropriately treated for a mental health condition.

The Ombudsman did not uphold the complaints, save for, to a limited extent, the complaint about medication, where he found that one drug had been prescribed outside of its normal approved usage, without a clearly recorded rationale for doing so. The Ombudsman found that the concern this caused Ms B amounted to an injustice.

The Ombudsman recommended that the Health Board apologise for this failing and address it with the relevant staff by using this report as a learning tool. The Health Board agreed to these recommendations.

Cwm Taf University Health Board - Clinical treatment in hospital
Case Number: 201804933 – Report issued in May 2020

Ms B complained that her late partner Mr C, was inappropriately discharged from Prince Charles Hospital ("the Hospital") following a prolonged admission for acute pancreatitis (a condition where the pancreas has become permanently damaged from inflammation and stops working properly). Mr C was re-admitted to the Hospital within 24 hours following a collapse at home. Ms B also complained that medical and nursing staff failed to act appropriately in response to Mr C's symptoms of sepsis, and that communication with the family around Mr C's diagnosis, condition and plans of care was poor.

The investigation found that although Mr C's discharge was appropriate, there was a failure to communicate the plan for his discharge to Ms B and to involve her in the process. Further, although Mr C received appropriate treatment for suspected sepsis, and appropriate measures were taken when he later became acutely unwell, the Health Board failed to keep Ms B informed of his diagnosis, and of the plans for his care. The Ombudsman found that the Health Board had failed to give Ms B the information and support that she needed, causing unnecessary worry.

To remedy the failings in this case, the Ombudsman recommended that the Health Board should apologise to Mrs C for its poor communication and that it pay her £250 for the unnecessary distress caused. The Health Board agreed to revise its nursing and discharge planning documentation to ensure that it supported and provided evidence of joint discharge planning and effective communication with families. The Health Board also agreed to produce an information leaflet for patients, families, and their carers on the management of acute pancreatitis.

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 201904369 – Report issued in May 2020

Mrs X complained that her husband, Mr X, was discharged too quickly from the Intensive Care Unit (ICU) at the Royal Gwent Hospital and that he was not reviewed by a consultant between his discharge from the ICU and his death.

The Ombudsman's investigation found that it was not appropriate to discharge Mr X to a ward as he required a higher level of care at that time than could be afforded on a ward. However, Mr X was discharged to the High Dependency Unit (HDU) rather than a ward (due to no beds being available on the wards). The Ombudsman investigation found that this mitigated the decision to discharge Mr X from ICU as he received HDU level care after his discharge. Therefore, this complaint was not upheld.

The investigation found that Mr X was not reviewed by appropriate senior staff the day before his death. This service failure caused an injustice to Mrs X due to the uncertainty caused by not knowing whether a review by appropriate senior staff could have changed the outcome.

The Health Board accepted the Ombudsman's recommendations to provide an apology to Mrs X and to remind relevant staff of the guidelines relating to consultant reviews, and specifically, that it remains the responsibility of the parent team (medical or surgical) to review patients who are discharged from critical care, even if they are located elsewhere in the hospital.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital
Case Number: 201807640 – Report issued in May 2020

Mrs X complained about the care and treatment provided by Swansea Bay University Health Board to her late husband Dr X, during the period 17 July-7 August 2018. The complaint centred on 3 admissions, and an outpatient appointment (culminating in the final hospital admission on 2 August) when Dr X had presented with a history of worsening pain in his pelvis. Whilst investigations were undertaken each time, no obvious diagnosis was reached and he was discharged until the final admission when further investigations (including a biopsy) were undertaken. Dr X however, deteriorated significantly having gone into liver failure, and was transferred to the intensive care unit (ITU) on 7 August where he sadly died on 9 August. A biopsy result that same day confirmed a highly malignant cancer in his liver and bone marrow.

The investigation found a number of failures in Dr X's care, albeit the outcome would not have changed given the aggressive type of cancer involved. A contrast CT scan (a detailed scan by computer and X-ray using a dye which highlights the parts of the body being examined) ought to have been undertaken some 9 days earlier than it was (on 31 July). This revealed nodules and a suspicion of malignancy requiring a liver biopsy. The biopsy was delayed as a Haematologist's (blood specialist) advice regarding performing blood clotting tests and administration of blood platelets was not fully followed, hence why the biopsy was not reported upon until after Dr X's death. The resulting delay in diagnosis, and in communication with Mrs X and Dr X about the reasons for the delay in the investigations caused them distress. Failings were confirmed in relation to one inappropriate discharge when the cause of Dr X's extreme pain was unknown, and a failure to adequately manage his pain. Further failures were found in relation to nursing record keeping on occasion. This included a failure at times to complete fluid intake and output charts. Apart from Dr X's first presentation, and the outpatient appointment (when the care, subsequent discharge, and actions taken were found to be appropriate) the complaints were upheld.

The Ombudsman made a number of recommendations, all of which the Health Board agreed to implement. These included an apology to Mrs X, training to staff within the Surgical Department on the review of pain management and patient communication as well as a dip sample audit of its records focusing on pain management. Additionally, refresher training on nursing record keeping requirements was recommended as well as relevant staff being asked to reflect on Dr X's case. Certain surgical staff were also asked to reflect on the care provided to Dr X at their next appraisal. Finally, the Ombudsman also recommended that the Health Board develop guidance on the tests (including clotting studies)

required when a liver biopsy is to be performed.

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 201905706 - Report issued in June 2020

Miss A complained about the care and treatment provided to her late father Mr B, by the Diabetic Podiatry and Tissue Viability Team (a multi-disciplinary foot care team specialising in managing complex wounds) at Ysbyty Ystrad Fawr. Mr B developed complications from diabetic foot ulcers requiring a below the knee leg amputation. He sadly died a few days after his surgery.

The Ombudsman's investigation found that the Health Board had used the generic term "necrosis" in the medical records to describe the presence of dead tissue. More precise terms were needed to identify the presence of infection. As per clinical guidelines, the Health Board also failed to take a sample for microbiological testing as close as possible to the start of antibiotic treatment. There was also a lack of evidence that Mr B was provided with enough information to make an informed decision when he turned down referrals to Vascular Services for review. The Ombudsman could not say whether the failings identified would have changed the outcome for Mr B given that he also had significant arterial disease. However, the failings caused some uncertainty around Mr B's care, which was an injustice to Mr B and Miss A.
It was recommended that the Health Board apologise to Miss A, share the report with relevant staff, and deliver training to the Podiatry Service about valid consent and appropriate documentation to support clinical practice and patient care.

Betsi Cadwaladr University Health Board & a GP practice in the area of Betsi Cadwaladr University Health Board - Clinical treatment in hospital & Medication> Prescription dispensing
Case Number: 201901187 & 201901123 - Report issued in June 2020

Mr B complained about the care and treatment provided to his wife, Mrs B, in the months leading up to her death in September 2017 by a GP practice ("the Practice") in the area of Betsi Cadwaladr University Health Board ("the Health Board") and by the Health Board. Mrs B had bipolar disorder which was treated with lithium medication.

The Ombudsman's investigation found that the Practice did not access and review Mrs B's lithium blood test results, which showed a marked increase, in a timely manner. Additionally, the prescribing of Metronidazole, an antibiotic, by the Practice before the lithium blood test result was known was likely to have contributed to Mrs B's already rising lithium serum level which, in turn, increased the risk of renal damage. These service failures caused significant injustice to Mr B, owing to the uncertainty caused by not knowing whether a timely review of, and response to, the lithium test result could have changed the outcome and whether not being prescribed Metronidazole could have changed the outcome.

The investigation found that the absence of a Shared Care Agreement between the Practice and the Health Board did not compromise Mrs B's care, and that the Health Board did not fail to make the Practice aware of the lithium blood test result. The investigation was unable to make a finding about Mr B's complaint that the Health Board's Psychiatrist failed to respond appropriately when Mrs B's lithium serum level rose to toxic levels.

The Practice accepted the Ombudsman's recommendations to provide an apology to Mr B, to share the report with relevant staff and to remind them of their responsibilities when seeking and reviewing test results and taking action in response to results. The Practice also accepted the recommendations to review how results for tests requested by the Practice are reviewed and actioned and implement any process improvements identified during this review.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number: 201901328 - Report issued in June 2020

A firm of solicitors complained about whether Mrs T had appropriate investigations and care for heart failure in April 2018, and whether she had been fit for discharge. Mrs T died of a heart attack 2 days after being discharged. They also complained about failings in communication with Mrs T's family, and the Health Board's failure to keep a record of a meeting with them.

The Ombudsman found that Mrs T was treated for acute kidney injury, which was considered to take precedence over her heart failure. However, Mrs T also had significant heart failure, but no investigations for this were carried out, no referral was made for a cardiology opinion and no treatment was offered. The Ombudsman concluded that it was not reasonable to focus solely on her kidney problem to the exclusion of her heart failure. He also concluded that, in view of Mrs T's clinical observations on the day of discharge, she was not fit for discharge. He upheld the complaint about Mrs T's care, although he could not say that the outcome for Mrs T would have been different. He also partly upheld the complaint about communication, in respect of the failure to keep a record of a meeting.

The Ombudsman made recommendations for an apology and a small redress payment to reflect the distress and uncertainty caused by the failings he identified. He also recommended that the report be used for learning, and that the Health Board conduct an audit on relevant wards for appropriate escalation of unwell patients in accordance with protocols.

A GP Practice in the area of Aneurin Bevan University Health Board - Clinical treatment outside hospital
Case Number: 201804554 - Report issued in June 2020

Mr A complained that:

- the GP Practice ("the Practice") acted unreasonably in relation to visiting his wife, Mrs A, at home following her discharge from hospital in October 2017
- the Practice failed to follow the correct procedure in issuing the medical certificate of cause of death.

The Ombudsman partly upheld the complaint. He concluded that, in the absence of adequate support from a specialist palliative care charity and District Nurses, the Practice's failure to visit Mrs A between 10 and 27 October (when the GP reported they had attempted to visit) was not acceptable.

The GP, in issuing the death certificate, confirmed they had seen Mrs A on 27 October. Although the GP said they had visited and seen Mrs A through her lounge window that day, Mr A said this was not possible as Mrs A did not go downstairs during this period. In view of such contradictory evidence, the Ombudsman was unable to make a finding in respect of the second part of the complaint.

The Ombudsman recommended the practice apologise to Mr A and that the GP involved reflect on their clinical practice in relation to the concerns raised in the complaint.

Aneurin Bevan University Health Board - Appointments/admissions/discharge and transfer procedures
Case Number: 201901095 - Report issued in June 2020

Mr and Mrs A's complaint centred on whether the inpatient discharge of Mrs A's elderly uncle, Mr B, from the Royal Gwent Hospital was safe and whether more should have been done in terms of his post-discharge care. Mr B, whose health issues included heart failure, lived in an extremely cluttered first floor bedsit accessed by a flight of stairs. Mr B was found dead at home shortly after his discharge. It was determined that he had died of bronchopneumonia. Mr and Mrs A also complained about the robustness of the Health Board's complaint response and whether it had learnt lessons from Mr B's case.

The Ombudsman's investigation found that there were nursing and documentation failings, including around Mr B's discharge, which meant the care he received was not as person-centred as it should have been. In particular, there was a lack of engagement by healthcare staff when it came to Mr B's wellbeing, social and home circumstances post-discharge. The Ombudsman found this was at odds with the Health Board's Discharge Policy. He was also critical that the Health Board's complaint response had not identified the failings around care. The Ombudsman concluded that the injustice for Mr and Mrs A was having to live with the uncertainty of not knowing whether, but for this missed opportunity, Mr B's post-discharge circumstances might have been improved as part of a holistic social care referral. In addition, the frustration caused to Mr and Mrs A of having to complain further might have been avoided. These aspects of Mr and Mrs A's complaint were upheld.

The Ombudsman recommended that the Health Board apologise to Mr and Mrs A for the failings, discuss the Ombudsman's findings at an appropriate clinical forum and review its discharge documentation and audit processes.

A GP Practice in the area of Hywel Dda University Health Board - Clinical treatment outside hospital
Case Number: 201900688 - Report issued in June 2020

Mrs A complained about her late husband's management and care by the GP Practice. Mr A died from methotrexate-induced pneumonitis (a life threatening lung disease which is a rare complication of methotrexate) in January 2018. She was concerned that the GP Practice had not learnt sufficient lessons from her husband's case.

The Ombudsman's investigation found that there was a missed opportunity by the GP to have stopped Mr A's methotrexate at a clinical consultation on 10 October when he was complaining of a cough. However, the Ombudsman concluded that it was not possible to say definitively that had Mr A's methotrexate been stopped at that stage his outcome would have been any different. Nevertheless, by the time Mr A stopped taking his methotrexate in late November his respiratory condition was very advanced and his prognosis therefore poor. As a result of the service failings Mrs A would have to live with the uncertainty of not knowing whether her husband's outcome could have been different had his methotrexate been stopped in the October. This was the injustice caused to her. This part of Mrs A's complaint was upheld.

The investigation found administrative failings, due to poor record keeping on the part of the GP, which meant the records did not provide a full clinical picture of Mr A's management and care. Additionally, the Ombudsman had concerns that the Practice had failed to identify this in the information it provided to the Health Board. As a result, this led to the Health Board's complaint response, on behalf of the Practice, being misleading.

Given the additional clinical and administrative failings identified had caused Mrs A an injustice, the Ombudsman concluded that the Practice could have done more to learn lessons from Mr A's case. This aspect of Mrs A's case was upheld. The Ombudsman recommended that the GP reflects on her management and record keeping and discusses the points of learning arising from Mr A's case with her appraiser. The GP Practice was also asked to learn from the additional clinical and administrative failings identified. The GP Practice confirmed that it would be introducing the clinical record keeping audits suggested by the Ombudsman.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201902792 - Report issued in June 2020

Mrs X complained that there was a delay by Betsi Cadwaladr University Health Board in investigating suspected cancer.

The investigation found that Mrs X experienced an unreasonable delay from referral to treatment. The Health Board acknowledged that there was a missed opportunity to upgrade Mrs X's referral to Urgent Suspected Cancer. The Ombudsman concluded that it was difficult to establish the impact of this failure. However, Mrs X may have received treatment sooner had the referral been appropriately triaged.

The Ombudsman found that Mrs X's surgical treatment was unaffected by the delay she experienced, however the addition of chemotherapy treatment may not have been needed had surgery been undertaken in a timely manner. The Ombudsman considered that the uncertainty arising from this finding was a significant injustice for Mrs X.

The Health Board agreed to implement the Ombudsman's recommendations to apologise and make a redress payment to Mrs X of £1,000, as well as procedural recommendations to be completed within six months.

Welsh Ambulance Services NHS Trust - Clinical treatment outside hospital
Case Number: 201903720 - Report issued in June 2020

Mr A complained that when his late wife, Mrs A, contacted NHS Direct Wales ("NHSDW") on 9 December **2018**, a Nursing Adviser ("the Nurse") gave her incorrect advice about her left-sided shoulder pain. Mr A felt that if his wife had been told to attend the Emergency Department urgently then her untimely death in the early hours of 10 December from a coronary artery blood clot might have been prevented. Mr A also complained about the Trust's complaint handling.

The investigation found that the Nurse had, at the time of the telephone call, provided appropriate advice to Mrs A, based on her presenting symptoms and responses to the Nurse's questions. This element of Mr A's complaint was **not upheld**.

The investigation found that, whilst the Trust had thoroughly investigated Mr A's complaint, it had failed to adequately explain in its complaint response why it had concluded that the Nurse's advice was appropriate. The Trust informed the Ombudsman during the course of the investigation that it had no facilities to record complaint meetings with complainants and was therefore not able to provide a copy of a recording of the complaint meeting with Mr A. This element of Mr A's complaint was therefore **upheld**.

The Trust agreed to implement the Ombudsman's recommendations that it apologise to Mr A within 6 weeks for its complaint handling failings, and to, within 12 months, consider how best to record meetings with complainants, and how to make those recordings available to complainants and any other relevant interested parties.

Welsh Ambulance Services NHS Trust - Ambulance Services
Case Number: 201904517 - Report issued in June 2020

Mrs B complained about the unacceptable delay in the attendance of an ambulance following an emergency call she made to the Welsh Ambulance Services NHS Trust for her husband, Mr B, on 6 February 2019. Specifically, Mrs B complained that the delay in the attendance of an ambulance caused significant distress and resulted in Mr B's death.

The investigation found that WAST incorrectly re-categorised Mrs B's call which resulted in a delay in the attendance of the ambulance. The Ombudsman found that Mrs B suffered an injustice as a consequence due to the prolonged worry and distress caused by the delay in an ambulance reaching their location. As a result, the Ombudsman upheld this part of Mrs B's complaint. The investigation also found that, although WAST incorrectly re-categorised Mrs B's call which led to a delay in the attendance of an ambulance, the delay did not contribute to Mr B's death. As a result, the Ombudsman did not uphold this

part of Mrs B's complaint.

The Ombudsman recommended that WAST ensured that the learning identified in this case was shared with all of its call handlers.

Hywel Dda University Health Board & Welsh Ambulance Services NHS Trust & A GP Practice in the area of Hywel Dda University Health Board - Clinical treatment in hospital & Ambulance Services & Clinical treatment outside hospital
Case Number: 201904157 & 201901209 & 201901190 - Report issued in June 2020

Mrs R complained about care provided to her sister, Mrs C. She said that the GP Practice failed to investigate Mrs C's head and neck pain and review her opioid medications appropriately. She also said that WAST failed to adequately assess Mrs C's condition and give appropriate advice. Finally, Mrs R said that the Health Board failed to investigate the cause of Mrs C's pain, adequately consider her other symptoms and provide appropriate treatment and advice to Mrs C.

The Ombudsman found that doctors at the GP Practice examined Mrs C appropriately, drew reasonable conclusions and requested relevant tests based on Mrs C's clinical picture. There was nothing to suggest that anything further was necessary. He also found that doctors provided appropriate advice on opioid pain relief, having considered both Mrs C's tolerance to it and the likelihood of Mrs C suffering side effects from it.

The Ombudsman also found that WAST adequately assessed Mrs C and that paramedics sought appropriate advice from an out-of-hours GP. The records demonstrated a thorough exploration of Mrs C's symptoms, as well as appropriate advice on managing them.

The Ombudsman found that the advice and treatment Mrs C received from the Health Board fell within the bounds of acceptable clinical practice. Her prescribed pain relief was appropriate and not excessive. In the context of Mrs C's interactions and clinical presentation with all three health services, there were no clear or obvious signs that Mrs C had an underlying condition. Furthermore, it was unlikely that further tests to investigate Mrs C's head and neck pain would have identified that she was also suffering from lung cancer.

However, it appeared that on 2 separate occasions hospital doctors assumed that Mrs C's initial diagnosis of age-related wear and tear affecting the spinal discs in her neck was correct, without exploring the possibility that there might have been an alternative underlying cause for Mrs C's pain. It did not appear that enough consideration was given to Mrs C's raised blood pressure and dizziness. This led to some uncertainty whether they represented any missed opportunity to identify a potential clue that Mrs C was suffering from more serious disease.

The Health Board agreed to apologise to Mrs R and her family for these omissions and to remind staff to be vigilant against diagnosis bias and to exclude all potential alternative diagnoses. It also agreed to review its policies on the management of patients presenting with sudden head and neck pain in line with relevant guidance, and to consider whether action should to be taken to ensure that patients returning to hospital within a short time span with worsening symptoms are reviewed by a senior clinician before they are discharged.

Cardiff and Vale University Health Board - Clinical treatment in hospital
Case Number: 201901050 - Report issued in June 2020

Mr X complained that Cardiff and Vale University Health Board failed to conduct a gastroscopy which Mr X said would have identified his mother's, Mrs G, stomach cancer earlier. Mr X said that due to this delay, his mother did not receive timely, relevant treatment before she died.

The Ombudsman's investigation found that an earlier opportunity to diagnose Mrs G's cancer had been missed when a barium meal was recommended rather than a gastroscopy. The Ombudsman also concluded that whilst treatment might have started sooner for Mrs G, he could not be certain that it would have necessarily altered the outcome for Mrs G. Nevertheless, this uncertainty was a significant injustice to Mr X and the Ombudsman upheld Mr X's complaint.

The Ombudsman recommended that the Health Board apologise to Mr X, share his report with the Gastroenterology department to ensure lessons are learnt and make a payment to Mr X of £750 to reflect the injustice of the delayed diagnosis and uncertainty of not knowing whether the outcome for Mrs G might have been different.

The Health Board agreed to carry out the Ombudsman's recommendations.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital
Case Number: 201806409 - Report issued in June 2020

Mrs A complained about the care that she had received from the former Abertawe Bro Morgannwg University Health Board ("the Original Health Board"). She said that the Original Health Board did not enable her to give informed consent to the surgical removal of her gall bladder. She stated that it did not investigate the location of her hernia appropriately before performing her gall bladder removal operation ("the Operation"). She said that it did not repair her hernia during that Operation, as previously agreed. She also complained about its complaint handling.

The Ombudsman found that the Original Health Board had given Mrs A unrealistic expectations about repairing her hernia during her Operation. He considered that Mrs A had suffered an injustice, in the form of distress and uncertainty, as a result. Consequently, he partly upheld the consent aspect of Mrs A's complaint. He determined that it had not been clinically necessary for the Original Health Board to pinpoint the location of Mrs A's hernia before her Operation because her hernia repair, after her emergency admission to hospital with an inflamed pancreas, had been a secondary consideration. He did not uphold the location element of Mrs A's complaint. He found that it had been clinically reasonable for the Original Health Board not to repair Mrs A's hernia during her Operation because of the risk of infection and recurrence. He did not uphold the repair part of Mrs A's complaint. He found that the Original Health Board had not clarified Mrs A's complaint with her at the outset or given her clear written responses to some of her concerns. He considered that those failings had caused Mrs A, in terms of distress and inconvenience, an injustice. He partly upheld the complaint handling aspect of Mrs A's complaint as a result.

Cwm Taf Morgannwg University Health Board ("the Current Health Board") became responsible for the services complained about after the events that led to Mrs A's complaint. Consequently, the Ombudsman recommended that the Current Health Board should apologise to Mrs A for the consent-related and complaint handling failings identified. He also asked it to pay Mrs A £250 and £125 in respective recognition of the impact of those failings. He recommended that it should take action to ensure that the complaint handling failings identified are not repeated. The Current Health Board agreed to implement these recommendations.

Hywel Dda University Health Board - Clinical treatment in hospital
Case Number: 201902060 - *Report issued in June 2020*

Mr B complained about the care and treatment that his wife, Mrs B, received during her admission to Glangwili General Hospital ("the Hospital"). Mr B complained that:

1. Clinicians were slow to suspect and identify that Mrs B's symptoms of respiratory distress and

reduced blood oxygen levels were due to the development of pulmonary embolisms ("PEs" – blood clots in the lungs).

2. A referral to the Respiratory Team was not completed or responded to in a timely manner.
3. The complaint response that he received from Hywel Dda University Health Board ("the Health Board") was excessively delayed and failed to address his substantive concerns.

The Ombudsman upheld Mr B's complaints. He found that ward clinicians were slow to suspect that Mrs B's symptoms indicated the development of PEs and, consequently, were slow to initiate treatment and/or to escalate the problem to the Respiratory Team. Whilst the Respiratory Team responded promptly to the referral it received, the Ombudsman found that the referral could have been sent by ward clinicians a week sooner. This delay increased the time that Mrs B was exposed to the risks associated with PEs, delayed the improvement of her symptoms and perhaps lengthened her hospital admission. Whilst Mrs B made a full recovery and this delay did not result in any long-term damage to her health, the consequences identified nevertheless amount to a significant injustice to Mrs B and her family. The Ombudsman also found that the time taken by the Health Board to respond to the family's complaint significantly exceeded NHS complaint-handling regulations.

The Ombudsman recommended that the Health Board provides Mr B with an apology for the identified care failings and, in recognition of the distress they gave rise to, makes a payment to him of £500. The Ombudsman also recommended that a further £250 should be added to this in recognition of the identified complaint handling failings.

The Ombudsman recommended that the Health Board ensures that the report is shared with and reflected upon by the Surgical Team at the Hospital and considers conducting a review of the case at the surgical mortality and morbidity meeting in light of a recent NCEPOD report on PE. Additionally, the Ombudsman recommended that the Health Board considers the feasibility of introducing an automated respiratory referral system for patients noted to have sudden and unexplained drops in oxygen saturations.

Finally, the Ombudsman recommended that the Concerns Team is reminded of the requirement to adhere to NHS complaint handling regulations in issuing explanatory update letters, and that it provides details of the review of the process of sending complaint responses by email referred to in its letter to this office of 13 September 2019.

The Health Board agreed to implement these recommendations.

A GP practice in the area of Betsi Cadwaladr University Health Board & Betsi Cadwaladr University Health Board - Clinical treatment outside hospital
Case Number: 201900622 & 201900557- Report issued in June 2020

Mrs G complained about the care and treatment that her late mother, Mrs W, received from her GPs ("the Practice") and from clinicians at Ysbyty Glan Clwyd ("the Hospital") in September 2017. Mrs G complained that:

1. GPs failed to adequately manage the "excruciating pain" that Mrs W developed after suffering a wedge-fracture of the spine.
2. GPs declined to conduct home visits when requested by family members and failed to refer Mrs W to the District Nursing Service ("the DNS") in a timely manner.
3. Clinicians at the Hospital's Surgical Assessment Unit, Orthopaedic Department and Emergency Department unreasonably declined to admit Mrs W despite requests to do so from her GP.
4. GPs and hospital clinicians were slow to suspect and appropriately investigate the possibility that

Mrs W had cancer.

The Ombudsman did not uphold complaint 1. He found that whilst there were difficulties in achieving effective pain control, this was due to the complex nature of Mrs W's condition and not to any shortcomings in the GPs' management of her analgesia. The Ombudsman upheld complaint 2, concluding that it was not acceptable that GPs failed to visit Mrs W at home and that the family's request for referral to the DNS was not recorded and acted upon. He also upheld complaint 3. The Ombudsman considered that the decision of the hospital teams not to admit Mrs W was clinically flawed and a considerable injustice to her and her family. Whilst the Ombudsman found no evidence that clinicians failed to investigate the possibility that Mrs W had cancer during her episodes of care between 2013-17, he determined that Mrs W's cancer diagnosis might have been made some 2-3 weeks sooner than it was. To this limited extent he upheld this complaint.

The Ombudsman recommended that the Health Board:

1. Provides Mrs G with a fulsome apology for the identified failings of care and, in recognition of the distress and trouble to which she was put in pursuing her complaint about these matters, makes a payment to her of £500.
2. Shares the report with the Clinical Director(s) responsible for the Orthopaedic, Surgical, Medical and ED Teams at the Hospital and demonstrates that its findings have been reflected upon and discussed with relevant clinicians
3. Reviews the processes by which on-call physicians deal with telephone requests from healthcare professionals seeking to have patients assessed or admitted to the Hospital and reminds senior physicians of the importance of referring patients across teams where appropriate.

The Ombudsman also recommended that the GP Practice:

- Provides Mrs G with an apology for declining to conduct home visits in respect of Mrs W on 13 and 18 September 2017 and for the communication/recording failure surrounding the referral to the DNS
- Provides evidence to the Ombudsman that GPs have considered how the Practice's Home Visit Policy might be amended in light of the identified failing.

Both the Health Board and the GP Practice agreed to implement these recommendations.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201807932 - Report issued in June 2020

Mr A complained about the care and treatment his sister, Miss B, received in hospital. Mr A complained that Miss B's medication was not administered in an appropriate or timely manner, and that her care plan was not completed so her individual care needs were not met. Mr A also complained that Hospital staff did not treat Miss B with dignity as they did not discuss her diagnosis and treatment plan with her directly. Finally Mr A said that there had been a failure to keep him and his brother, Mr C, informed about Miss B's clinical condition.

The investigation found that the arrangements made to administer Miss B's medication had not been assessed in accordance with the Health Board's guidelines. It also found that there had been a failure to assess and produce a bespoke care plan that met Miss B's complex needs. Finally, the investigation found that communication with Miss B and her family had been poor, and as a result, they did not fully understand Miss B's diagnosis, prognosis and treatment plan.

It was recommended that the Health Board apologise to Miss B and remind nursing staff of the Health Board's policies and guidelines on the self-administration of medication, NEWS, nutrition, fluid balance charts, pressure ulcer prevention, caring for patients with epilepsy, manual handling, and of the need to create a robust and personalised care plan. It was also recommended that the Health Board audit its records to ensure that robust and personalised care plans are being created, and the administration of medication guidelines are being followed. Finally, it was recommended that those identified in this complaint consider this report, and any lessons identified be shared.

A GP practice in the area of Swansea Bay University Health Board - Patient list issues
Case Number: 201901358 - Report issued in June 2020

Ms X complained that following a complaint she made to the Practice about the way she had been spoken to over the telephone by a receptionist and GP at the Practice, she did not receive a response to her complaint and she was removed from the Practice's list of patients. Ms X was aggrieved that the Practice removed her from its list due to a social media post she made in March 2019.

The investigation found that shortly after Ms X had submitted her complaint to the Practice in March, the Practice Manager responded in writing regarding the complaint about the Receptionist and informed Ms X that the GP had been made aware of the complaint about her. The GP subsequently responded in June. Given that the GP had been away from work for a time (for personal reasons), it was not an unreasonable delay before responding to Ms X's complaint. The GP provided an appropriate apology for the delay in responding to Ms X's complaint. The complaint about the Practice's failure to respond to Ms X's complaint was **not upheld**.

The investigation found that the immediate removal of Ms X from the Practice list, without her having previously had any warning regarding her conduct, demonstrated a failure on the part of the Practice to act in accordance with the relevant law, guidance and its own policy. That amounted to maladministration. The improper, disproportionate and unfair removal of Ms X from the Practice list was itself an injustice to her. The complaint about Ms X being improperly removed from the Practice list was, therefore, **upheld**.

The Practice agreed to provide Ms X with a meaningful apology for unfairly and inappropriately off-listing her and for the inconvenience, distress and anxiety this caused her. It also agreed to review its policy for off-listing to ensure that it accords with the relevant obligations and did not contain any obvious errors.

Not Upheld

Betsi Cadwaladr University Health Board - Medical records/standards of record-keeping
Case Number: 201807528 – Report issued in April 2020

Mrs X complained that Betsi Cadwaladr University Health Board ("the Health Board") failed to investigate concerns raised about the care her husband Mr X, received at a Care Home in its area ("the Care Home") in May, June and July 2017. Mrs X also complained that the Health Board did not provide the Care Home with Mr X's medical records in a timely manner, and that it did not handle her complaints properly.

The investigation found no evidence that staff at the Health Board recorded any concerns that Mr X was at risk of harm while in the care of the Care Home. Without any evidence that there were concerns or reasonable cause to suspect that Mr X was an adult at risk, the investigation found that there was no reason for the Health Board to have raised concerns. The investigation found that the Health Board should have (and did) send Mr X's medical records to his GP, not the Care Home, which was in line with the relevant guidance. In relation to complaints handling, the investigation found that although there was a short delay in acknowledging Mrs X's complaint by the Health Board, this did not cause Mrs X any

injustice, and otherwise Mrs X's complaint was handled appropriately.

Mrs X's complaints were therefore not upheld.

Welsh Ambulance Services NHS Trust - Ambulance Services
Case Number: 201905243 – Report issued in May 2020

Mrs A complained on behalf of her daughter, Mrs B, that the Welsh Ambulance Services NHS Trust ("the Trust") did not respond in a timely manner to 3 emergency calls made on 21 September 2019 in relation to Mrs B's husband, Mr B.

The Ombudsman's investigation found that all 3 calls were correctly categorised and appropriate searches were made to try to source an emergency ambulance to attend the calls. The investigation found that the Trust appeared to have made every effort to attend to Mr B as soon as reasonably practicable within the resources it had available and the complaint was not upheld.

However, it was evident that delays in transferring patients into the care of the health boards seriously affected the ability of the Trust to respond on this occasion. It was noted that the Trust is working with the health boards to negate these hospital delays, and this issue has been previously highlighted by the Ombudsman.

Cwm Taf Morgannwg University Health Board - Clinical treatment in hospital
Case Number: 201904807 – Report issued in May 2020

Ms B complained that her mother, Mrs F, did not receive appropriate care and treatment from the Health Board when she attended the Emergency Department on 2 November 2018. Ms B raised concerns that Mrs F was not investigated for a water or chest infection and was not prescribed antibiotics.

The investigation found that Mrs F underwent appropriate tests and investigations when she attended the Emergency Department on 2 November 2018. The investigation also found that there was no evidence that Mrs F was suffering with an infection and there was no indication that she should have been prescribed antibiotics. The Ombudsman found that the overall care and treatment provided to Mrs F was reasonable. As a result, the Ombudsman did not uphold the complaint. However, it was noted that the Emergency Department Doctor should have provided safety-netting advice and encouraged Mrs F to contact the palliative care team. The Ombudsman suggested that that the Health Board should draw the criticisms identified to the attention of the Emergency Department Doctor.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201902725 – Report issued in May 2020

Mr D complained about the care and treatment provide to his wife, Mrs D, by the Health Board prior to her sad death on 4 November 2018. Mr D complained that the Health Board should have identified Mrs D's cancer sooner.

The investigation found that the Health Board carried out prompt, timely and appropriate investigations into the primary cause of Mrs D's cancer. The investigation also found that the decision to stop further investigations into the primary source of Mrs D's cancer was appropriate and took into account the wishes of Mrs D. The Ombudsman found that the care and treatment Mrs D received was in accordance with the relevant clinical standards. As a result, the Ombudsman did not uphold the complaint. However, it was noted that the Health Board did not carry out a specific type of blood test in its initial blood testing of Mrs D. The Ombudsman suggested that the Health Board considered incorporating the blood test into its initial blood testing of patients with suspected cancer without a clearly suspected primary site.

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 201905598 - Report issued in June 2020

Miss A complained that the Health Board failed to take appropriate steps to prevent and/or minimise the development of her baby son's plagiocephaly (a condition where the head is flattened on one side), misdiagnosed a hernia, and failed to discharge her son in a timely manner.

The Ombudsman's investigation found that the Health Board took appropriate steps to minimise the development of her son's plagiocephaly including reviews by a Physiotherapist. It also found that it was appropriate to transfer Miss A's son to another hospital outside the Health Board's area for a specialist surgical review of a groin swelling before his discharge. The investigation found that her son could have been discharged a few days earlier as he no longer required oxygen or cardiorespiratory monitoring and was fully feeding. However, it was necessary to conduct a surgical review (as above) and, when no surgery was considered necessary, her son was discharged the following day. As a result, the Ombudsman did not uphold the complaints.

Aneurin Bevan University Health Board - Clinical treatment outside hospital
Case Number: 201901908 - Report issued in June 2020

Ms X complained that the Health Board did not diagnose her mental health condition promptly and reasonably between January 2017 and February 2018, and did not provide reasonable care and treatment for her mental health condition over the same period.

The investigation found that it was reasonable for the Health Board to provide 3 possible diagnoses in May 2017 and work to determine which was the correct diagnosis. It also found that the lack of a formal diagnosis did not affect the treatment Ms X received and that the medication and treatment she was provided with were appropriate. The investigation found that the care and treatment given to Ms X was reasonable, initially by the Health Visitors and then by the Mental Health Services.

A GP practice in the area of Betsi Cadwaladr University Health Board - Clinical treatment outside hospital
Case Number: 201807526 - Report issued in June 2020

Mrs X complained about the care and treatment given to her late husband, Mr X, by a GP Practice in the area of Betsi Cadwaladr University Health Board. Specifically, Mrs X complained that the GP who met Mr X on 5 May 2017 attempted to discuss end of life care for him inappropriately, and the GP who saw Mr X on 8 June failed to diagnose a serious infection which led to Mr X's hospitalisation.

The investigation was not able to determine whether a conversation about end of life care took place on 5 May, in light of conflicting evidence. It found that it would have been appropriate for a conversation about end of life care to have taken place with Mr X, given his circumstances, but that if the manner in which this was discussed caused distress, this should be a matter of reflection for the GP.

The investigation did not uphold Mrs X's complaint that the GP who saw Mr X on 8 June failed to diagnose a serious infection. It found that the examination of Mr X on 8 June was reasonable, and the treatment provided to Mr X was reasonable and appropriate.

Early Resolution or Voluntary Settlement

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 201906777 – Report issued in April 2020

Ms F complained that the Health Board had inappropriately prescribed Haloperidol to her partner, Mr M, who suffered from Parkinson's Disease, during his admission to a rehabilitation hospital placement in April

2019. Ms F raised this concern with the Health Board through an Advocate, and also complained that the Health Board failed to address her concerns, and to engage with them to try to put things right.

The Ombudsman established during a previous investigation into a different period of Mr M's care that he had been given a single dose of Haloperidol. He noted at that time that Haloperidol should never be given to patients with Parkinson's Disease and its prescription was contraindicated by the British National Formulary and contrary to Health Board policy.

In this case, the Ombudsman found that the Health Board should have investigated this further period of Mr M's care and the additional doses of Haloperidol given to him. The Health Board agreed to apologise for previously failing to address this and to fully investigate the circumstances surrounding the additional prescriptions identified by Ms F. It also agreed to consider whether anything further needed to be done to prevent a recurrence of any failings.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 202000050 & 202000005 – Report issued in April 2020

Mrs X complained that the Health Board had not responded to her further queries to it. She stated that she had written to the Health Board on 6 November and 3 December 2019 with points arising from the formal complaint responses that the Health Board had given. However, despite the Health Board acknowledging receipt of these letters and indicating that it would respond, Mrs X had heard nothing further from the Health Board. She therefore complained to the Ombudsman.

We contacted the Health Board. It had always been the Health Board's intention to provide further responses to Mrs X's queries. It agreed to do this by 14 August 2020.

Cwm Taf Morgannwg University Health Board - Clinical treatment in hospital
Case Number: 201906192 – Report issued in April 2020

Mr X complained about his father's care at the Health Board specifically that it failed to diagnose his stroke in 2018, following a GP referral, and that he received inappropriate care as a result. Mr X was also concerned that it was not until the following year that his father was aware that he had experienced a stroke. Mr X complained to the Health Board, but considered that its investigation did not address his complaint.

The Ombudsman considered there were shortcomings in the Health Board's management of the complaint, particularly as some of Mr X's concerns had not received a response and that it had left him in the position of having further queries about his father's care.

The Ombudsman considered that the complaint was open to Early Resolution and settled the complaint on the basis of the action the Health Board agreed to take; an apology for the management of the complaint, a response to Mr X's outstanding concerns and further queries since the complaint response, and to facilitate a meeting to discuss his concerns.

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 201906838 – Report issued in April 2020

Mr X complained to the Health Board about the care that was provided to his client, Ms A by the Newport West Community Mental Health Team. Following receipt of the Health Board's complaints response, Ms A remained dissatisfied about how the complaints handling process was undertaken; the impartiality of the investigating officer; the accuracy of the Health Board's response and the support that she received during her withdrawal from medication.

Whilst noting that Mr X sought to obtain answers to Ms A's outstanding concerns, the Ombudsman felt it would be helpful to Ms A to receive a further response from the Health Board in order to address those matters. After making enquiries with the Health Board, it agreed to undertake the following action in settlement of the complaint:

- To provide a written response to Ms A's outstanding concerns within 4 months of the Ombudsman's decision being issued.

The Ombudsman was satisfied that the action which the Health Board agreed to take was reasonable and would resolve Mr X's complaint.

Cwm Taf Morgannwg University Health Board - Clinical treatment in hospital
Case Number: 201906605 – Report issued in April 2020

Miss X complained about her experience surrounding her discharge from Prince Charles Hospital and her postnatal care following the sad loss of her baby. Miss X stated that she remained dissatisfied with the outcome of her complaint following receipt of the Health Board's complaints response.

The Ombudsman noted that some of the issues which Miss X raised, had not been brought to the Health Board's attention at the outset of her complaint. Thus, the Health Board had not had the opportunity to fully respond to Miss X's concerns, which he noted as follows:

- the accuracy of information about the time it would take the Health Board to carry out a post-mortem and contact her to discuss the results
- the lack of contact details provided for the Labour Ward, and the manner in which information was communicated to inform her that the post-mortem results were available
- the length of time taken to obtain an appointment during which the post-mortem results could be discussed.

The Health Board agreed to settle Miss X's complaint, on the basis that it would provide a written response to Miss X regarding her concerns within 2 months of the Ombudsman's decision being issued.

The Ombudsman was satisfied that the action which the Health Board agreed to take was reasonable and would resolve Miss X's complaint.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201906101 – Report issued in April 2020

Mr X complained to the Health Board about the care that his father received whilst he was an inpatient on a ward in Ysbyty Gwynedd. Following receipt of the Health Board's response to his complaint, Mr X remained dissatisfied because in his view, the response was selective and did not encompass the actual events. In making a complaint to the Ombudsman, Mr X included a document titled "Concerns raised with health board reply" which set out his outstanding concerns and highlighted sections of his father's medical records which he believed contradicted the Health Board's earlier response.

Whilst noting that Mr X sought to obtain answers to his outstanding concerns, the Ombudsman was of the view that the Health Board was in the best position to provide those answers. After making enquiries with the Health Board, it agreed to undertake the following action in settlement of Mr X's complaint:

- To provide a written response to Mr X's outstanding concerns as raised within the document titled "Concerns raised with health board reply" within 4 months of the Ombudsman's decision being issued.

The Ombudsman was satisfied that the action which the Health Board agreed to take was reasonable and would resolve Mr X's complaint.

Hywel Dda University Health Board - Clinical treatment in hospital
Case Number: 201907309 – Report issued in April 2020

Mr L complained about the care and treatment that had been provided to his late mother and that following a meeting with the Health Board in November 2019 it had failed to provide him with a copy of the transcript of the meeting.

By way of settlement, an apology and a copy of the transcript was sent to Mr L on 27 March 2020.

Hywel Dda University Health Board - Clinical treatment in hospital
Case Number: 201902392 – Report issued in April 2020

Ms B complained on behalf of Mr A, that following a new diagnosis of Barrett's Oesophagus (a condition where the cells of the oesophagus grow abnormally) in March 2013, the Health Board failed to advise him of the associated risk of developing oesophageal cancer and to arrange ongoing monitoring of his condition. Mr A developed symptoms and was diagnosed with advanced oesophageal cancer in December 2017. He sadly died shortly after Ms B made her complaint to the Ombudsman.

The Ombudsman found that, contrary to the relevant professional guidance, the Health Board failed to arrange appropriate follow-up and to advise Mr A about future management and the possible long-term consequences of his condition. The Health Board's written responses to Ms B's complaint also contained significant inconsistencies.

In settlement of the complaint, the Health Board agreed to apologise to Ms B, to pay her £250 in recognition of its poor handling of her complaint, and to investigate how the inconsistencies in its written responses arose. The Health Board also agreed to acknowledge the failings in care identified in this case, to instruct an independent expert to review the standard of care, to implement any recommendations arising from this expert report, to engage the NHS redress procedure if appropriate, and to disseminate the learning from the complaint to the relevant clinicians.

Cwm Taf Morgannwg University Health Board - Clinical treatment in hospital
Case Number: 201906133 – Report issued in May 2020

Mrs B complained about the treatment provided to her late father by Cwm Taf Morgannwg Health Board ("the Health Board"). She also complained about events that occurred following his death. Following a meeting with the Health Board in November 2019, Mrs B received a written response. She said the response failed to answer all of her questions and it was contradictory to the information provided during the meeting.

Upon reviewing the complaint response letter provided by the Health Board in January 2020, the Ombudsman found that Mrs B's complaint had not been considered in accordance with The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. It appeared that the Health Board had considered that Mrs B's complaint related her treatment following her father's death and it did not extend to treatment provided to her father.

The Ombudsman contacted the Health Board and it agreed to:

- consider the full extent of Mrs B's complaint and provide her with a comprehensive response in

accordance with the NHS Wales 'Putting Things Right' guidelines.

The Ombudsman was satisfied that this would provide a resolution to the issues considered in this complaint.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201907411 – Report issued in May 2020

Mrs X complained that the Health Board had failed to respond formally to points that she had raised with it in relation to a complaint about treatment. The Health Board acknowledged that there was a response outstanding.

It agreed to provide the outstanding complaint response to Mrs X by Friday 3 July 2020.

A GP practice in the area of Betsi Cadwaladr University Health Board - Clinical treatment outside hospital
Case Number: 202000144 – Report issued in May 2020

Mr X complained that a Medical Practice ("the Practice") had not dealt with his complaint formally in relation to a concern regarding providing him with monthly prescriptions.

The Practice agreed to undertake the following in settlement of Mr X complaint:

By 29 May 2020, allowing for post:

- Issue a response letter to Mr X addressing his concerns.

The Ombudsman considered this to be an appropriate resolution to the complaint.

Aneurin Bevan University Health Board - Clinical treatment outside hospital
Case Number: 202000138 – Report issued in May 2020

Mr X complained about the standard of care provided to him during his admission to Nevill Hall Hospital in March 2020. Mr X said that he submitted a complaint to Aneurin Bevan University Health Board but he was not satisfied with the response it provided on 3 April 2020.

The Ombudsman took into account that as part of the Health Board's investigation, it had already provided a reasonable explanation a number of points raised by Mr X, and it had carried out relevant action to address and/or resolve matters, which included an apology for the failings identified and a reminder issued to relevant staff about their responsibilities. The Ombudsman also noted that there were a number of points raised with the Health Board which were not addressed adequately, or indeed at all. The Ombudsman contacted the Health Board and it agreed to provide Mr X with a written response to the points highlighted within 30 days of the date that the decision was issued.

The Ombudsman was satisfied that this would provide a resolution to the issues considered in this complaint.

Swansea Bay University Health Board - Clinical treatment outside hospital
Case Number: 201906932 – Report issued in May 2020

Mr A complained that after many years of waiting for bariatric surgery, the Health Board decided that he was no longer a suitable candidate and did not provide him with a clear explanation of the rationale of its decision. Mr A felt that he had been treated unfairly, particularly as the psychology assessment used to

inform the Health Board's decision was over 2 years old.

The Ombudsman found that the Health Board had not clearly explained the reasons why Mr A was deemed unsuitable for surgery.

In settlement of the complaint, the Health Board agreed within 20 working days to provide Mr A with a written explanation of the rationale for its decision and details of how Mr A could access a copy of his medical records.

Betsi Cadwaladr University Health Board - Clinical treatment outside hospital
Case Number: 202000040 – Report issued in May 2020

Miss X complained about the treatment she received from the maternity unit at Glan Clwyd Hospital in September 2018. Whilst Miss X had received a response from the Health Board, to her concerns, she remained dissatisfied with that response and had requested a meeting to discuss her outstanding concerns.

The Ombudsman found that whilst the Health Board's complaint response invited Miss X to have a discussion about its investigation into your concerns, Miss X's request for such a meeting had not taken place. During the course of the Ombudsman's enquiries it was established that Miss X and the Health Board had been in recent communication.

The Health Board has agreed for Miss X to have the opportunity to speak with the investigating officer who investigated her concerns. It was agreed that Miss X would be contacting the Health Board by the end of May to arrange a suitable date and time for a telephone discussion with the investigating officer.

Aneurin Bevan University Health Board - Clinical treatment outside hospital
Case Number: 202000320 – Report issued in May 2020

Mr X complained that in responding to his concerns about the lack of care and support provided to his partner from mental health services, the Health Board had not addressed a particular incident whereby, following an appointment, his partner was taken out of the hospital in a wheelchair by a doctor and left alone outside.

In considering the complaint, the Ombudsman was concerned that whilst the response from the Health Board addressed a number of issues, it did not address this incident. Accordingly, in settlement of the complaint the Health Board agreed to provide Mr X, by 30 June 2020 with a full explanation of the circumstances that led to his partner being left outside the hospital.

Aneurin Bevan University Health Board - Clinical treatment outside hospital
Case Number: 202000131 – Report issued in May 2020

Mrs B complained to the Ombudsman about the Health Board's management of the complaint regarding the inpatient care and treatment of her mother. Mrs B said that that there were multiple administrative errors including incorrect personal details in correspondence and reports and a breach of confidentiality. Mrs B said that the Health Board failed to keep her regularly updated, and because of the protracted process and continued inaccuracies, she was denied the opportunity to grieve for her mother.

The Ombudsman found that whilst the Health Board had acknowledged how difficult the 18 month wait for the final outcome would have been for Mrs B, it did not offer her an apology or an explanation for the delays. Neither did it acknowledge or apologise for the administrative errors that had occurred.

In settlement of Mrs B's complaint, the Health Board agreed within 20 working days, to provide Mrs B with a full apology and explanation for the poor complaint handling. The Health Board also agreed to offer Mrs B £250 financial redress and to provide Mrs B with assurances of action it has taken to avoid future repetition of the shortcomings she experienced. The Ombudsman considered this to represent an appropriate settlement.

Swansea Bay University Health Board - Clinical treatment in hospital
Case Number: 201901230 – Report issued in May 2020

Mrs A complained that the Health Board failed to obtain her informed consent for iron infusion therapy, and to monitor her properly whilst the iron infusion was being administered through a cannula (a thin tube inserted into the vein to administer medication) placed in her arm. Mrs A was injured during the iron infusion when the medication leaked from the vein into the surrounding tissue causing temporary swelling and bruising and permanent brown staining of the skin around the infusion sight. Mrs A went on to develop symptoms of weakness in her arm and wrist which she also attributes to the injury.

The investigation found that the Health Board had failed to warn Mrs A of the possibility of permanent skin staining from the iron infusion, and that it did not obtain appropriate consent from her for the procedure. Further, there was no evidence that the cannula was flushed before the iron infusion to ensure that it was not blocked, or that Mrs A was appropriately monitored and observed during the procedure. The nursing documentation also failed to meet professional standards.

On reflection, the Health Board agreed to write to Mrs A to confirm that it would consider the impact of the failings identified under the redress arrangements for complaints about the NHS in Wales. The Health Board also agreed to provide training to the relevant nursing staff on standards for iron infusion therapy, to undertake a nursing documentation audit and act upon the findings to ensure that local and national standards were being met, and to put in place a consent process for iron infusion therapy.

Swansea Bay University Health Board - Clinical treatment in hospital
Case Number: 201905514 – Report issued in May 2020

Mr O complained about the consent process which preceded his wife receiving chemotherapy treatment in January 2019. He said that his wife was not given adequate and appropriate information to make an informed decision, insufficient consideration was given to her request to be referred to a clinical trial, and that his wife did not give formal consent to the treatment before it was administered. Mr O also questioned whether the dosage of the chemotherapy was adjusted appropriately.

The Health Board on reflection, identified a breach in its duty of care to Mr O's wife in relation to the consent process, owing to the absence of a signed consent form. It offered to investigate this further, and to consider the impact of this under the NHS process for dealing with complaints about its service: Putting Things Right ("PTR").

The Ombudsman found that the Health Board should reconsider the whole consent process, including the impact of the failure to obtain formal written consent. The Health Board agreed to write to Mr O within 2 weeks, to apologise for the breach in its duty of care and that this had not been addressed earlier. It also agreed to review the whole consent process, including obtaining a view, independent from the treating clinician, on the appropriateness of the type and dose of chemotherapy administered. It also agreed to outline the improvements it had made, since the time of the events, to ensure the consent process was more robust, and to complete all these actions within the timescales provided under PTR.

A GP practice in the area of Cwm Taf University Health Board - Clinical treatment outside hospital
Case Number: 201907543 - Report issued in June 2020

Mr X complained that he had been prescribed an inappropriate dose of anticoagulant medication (Apixaban) which had resulted in distressing side effects for him. He was prescribed an alternative medication on review and this resolved his side effects. He also made additional complaints to the Practice about treatment subsequent to his complaint.

The Ombudsman noted that the dose prescribed to Mr X was in line with the clinical guidelines outlined in the British National Formulary (BNF) which was a recognised medication guide used by GPs. The dose prescribed to Mr X by the GP Practice was therefore reasonable.

The Ombudsman noted that the GP Practice had not as yet formally responded to the subsequent complaints made. The GP Practice therefore agreed to provide a formal written complaint response to Mr X by 26 June 2020.

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 202000262 - Report issued in June 2020

Ms X complained about the pain and suffering her late father endured at the end of his life, and the distress caused to the family to see him in pain.

The Ombudsman noted that whilst the Health Board responded to the complaint, it did not do so in line with the Putting Things Right ("PTR") regulations. The Health Board offered its sincere apologies to Ms X and her family and agreed to issue a PTR response.

Cwm Taf Morgannwg University Health Board - Clinical treatment in hospital
Case Number: 202000440 - Report issued in June 2020

Mrs X complained that Cwm Taf Morgannwg Health Board ("the Health Board") had not arranged a meeting or telephone conference as requested with senior staff to discuss her concerns about the care and treatment provided to her late father when he attended A&E at Prince Charles Hospital in October 2019.

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

By 4 October 2020, the Health Board will arrange a meeting or telephone conference with Mrs X and senior staff to discuss her concerns. However, should there be a second wave of Covid-19, the timescale may be subject to change.

The Ombudsman considered this to be an appropriate resolution to the complaint.

Hywel Dda University Health Board - Clinical treatment in hospital
Case Number: 201906916 - Report issued in June 2020

Miss X complained about the care and treatment provided to her late grandmother Mrs Y, by Hywel Dda University Health Board, in particular that she was not treated as a person with capacity. Concerns were raised about the monitoring of Mrs Y's fluid intake and output, why she was given intravenous fluids and whether excess fluid retention had led to Mrs Y's heart failure and subsequent death. Miss X also complained about poor communication and record keeping and was unhappy with the Health Board's complaint response.

The Ombudsman concluded that the Health Board had undertaken a thorough investigation of the complaint, which involved a review of medical records and speaking with the staff involved. A detailed complaint response had been provided which acknowledged shortcomings in relation to waiting times, the

standard of nursing care, poor communication and breach of hospital policy. The Health Board has apologised where appropriate and taken steps to share concerns with staff. The Ombudsman was concerned that some explanations and conclusions were not sufficiently clear in the complaint response. The Health Board agreed to provide a more detailed response and explanation in relation to aspects of care and treatment including fluid intake/output monitoring, provision of intravenous fluids, fluid retention and the its conclusion as to the cause of her death. The response was to be provided within 40 working days.

The Ombudsman's view was that the above action was reasonable to settle Miss X's complaint.

A GP practice in the area of Betsi Cadwaladr University Health Board - Clinical treatment outside hospital
Case Number: 201905503 - Report issued in June 2020

Ms X complained that the Surgery did not carry out an adequate assessment to evaluate her mother's mental capacity in respect of a Lasting Power of Attorney ("LPA").

The Ombudsman's assessment found that the mental capacity assessments carried out for Ms X's mother did not appear to have fully complied with good practice, as highlighted by the Ombudsman's independent professional adviser. As a result, the Ombudsman proposed the following settlement:

1. Within three months, the Surgery should provide the information shared by his office to all GPs as a reminder of good practice regarding conducting and recording a reasonable mental capacity assessment and provide evidence of this having been done.
2. Within three months, the Surgery should discuss this complaint and the information shared in a meeting and provide evidence of this having been done.

The Surgery agreed to the settlement. As the mental capacity assessment had been carried out in respect of a LPA, the Ombudsman did not suggest that a further assessment was carried out as this was a private matter, outside the scope of the Surgery's NHS work.

Hywel Dda University Health Board - Clinical treatment in hospital
Case Number: 202000331 - Report issued in June 2020

Mr A complained about the Health Board's handling of the complaint he submitted in September 2018. Due to the nature of the complaint, the Health Board decided that it should be considered by its Safeguarding division, rather than Putting Things Right. In December 2018 the Health Board's Safeguarding division confirmed that the concerns should be dealt with by the Police. Mr A informed the Health Board that he was disappointed with its decision and that he wanted it to consider his complaint.

In May 2019 the Health Board said that it would write to Mr A, pending the conclusion of the police investigation. Mr A met with the Health Board in May and October 2019. The Health Board agreed that it would provide a written Corporate response to Mr A, confirming aspects of his concerns. In April 2020 Mr A contacted the Health Board again, prompting the written response it had agreed to provide 6 months previously.

The Ombudsman considered the Health Board's response to be both lacking in sufficient detail and not in accordance with the requirements of the Putting Things Right scheme for responding to complaints.
In settlement of this complaint, within 20 working days, the Health Board agreed to provide Mr A with a Putting Things Right response to his complaint and an apology for the delays that have occurred.

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 202000187 - Report issued in June 2020

Mrs X complained that a laser procedure to treat problems with her left eye in May 2018 was not carried out correctly and that following this procedure her eyesight in that eye deteriorated. She also expressed concerns that the doctor who performed the procedure was a trainee and that he was not supervised sufficiently.

The Ombudsman's enquiries found that whilst Mrs X complained to Aneurin Bevan University Health Board ("the Health Board") about the procedure that was undertaken in May 2018, the Health Board's response referred to a different procedure that took place on 27 June 2019. The Health Board accepted that it's complaint response did not relate to the procedure Mrs X complained about. Whilst at the time Mrs X complained to the Health Board the matter would have fallen outside the time limit that is normally applicable for raising concerns, following discussions with the Health Board, it has agreed to take the following actions:

1. The Health Board will apologise for its failure to appreciate that Mrs X's complaint related to a procedure in May 2018 and that therefore its response was incomplete.
2. The Health Board will conduct a review of Mrs X's clinical records to try to establish whether the procedure she received in May 2018 was undertaken appropriately and did not lead to a deterioration

The Health Board indicated it would aim to undertake these actions within 4 weeks.

Swansea Bay University Health Board - Clinical treatment in hospital
Case Number: 201906729 - Report issued in June 2020

Mrs W complained about the management of her father (Mr Y's) care after he was diagnosed with lung cancer. His Surgeon initially agreed to operate. He first arranged another test, and then sought other medical advice to fully assess the surgical risks. The test and the Surgeon's meeting with another clinician, where they agreed to operate, were delayed, by which time a separate visit to hospital by Mr Y had also revealed cancerous growth in his brain. Mrs W was concerned about the time her father had waited for an operation; whether that had contributed to the worsening of his condition, and why, in the meantime, other treatment options were not discussed with him. She was also concerned about the lack of information given to him about how his medical care was to proceed once the secondary cancer was detected.

While Mr Y and Mrs W met with the Health Board to discuss their concerns soon after the brain cancer was detected, they waited over 5 months for the meeting notes and the Health Board's formal response to be sent to them. Mr Y died during that wait. The Ombudsman was concerned about that delay, and he agreed with the complainant that the Health Board's written response did not adequately address all the matters discussed at the meeting, including alternative treatment options, communication issues and what action had been taken by the Health Board about those issues.

In the light of those concerns the Health Board agreed to settle the complaint within 2 months of the Ombudsman's decision by;

1. Apologising for the failures in communication that occurred during Mr Y's wait for surgery. Also setting out any action that had or would be taken to help convey full and accurate information / options for treatment to patients whose care fell between several specialities, and whose clinical management plans were complex.
2. Providing as much explanation as possible to help address the family's concern about the treatment options that might otherwise have been explored or followed in the period Mr Y was left

waiting for his surgical treatment to go ahead, and:

3. Apologising for, and explaining the delay in providing the family with a written record of the complaint meeting.

Aneurin Bevan University Health Board - Appointments/admissions/discharge and transfer procedures
Case Number: 201901356 - Report issued in June 2020

Mrs T complained that she was wrongly removed from a waiting list for a spinal injection following concerns she raised, which the Health Board deemed a formal complaint. Mrs T said that she was then referred to a neighbouring health board but was placed at the bottom of the list with a wait of approximately 48 weeks for an initial consultation. Mrs T was also unhappy at the Health Board's complaint response which she said contained numerous inaccuracies.

The investigation found that whilst Mrs T had indicated she wished to raise a complaint, the Health Board removed her from the waiting list too hastily and was inappropriately referred to a neighbouring health board without discussion or her consent. Further, and on reflection, the Health Board acknowledged that some elements of its complaint response were either misleading or insensitive.

In settlement of the complaint, the Health Board agreed to apologise to Mrs T and reinstate her on the waiting list to the exact position she had been prior to her removal.

Community Facilities, Recreation and Leisure

Early Resolution or Voluntary Settlement

Conwy County Borough Council - Grass cutting/verges
Case Number: 201905485 – Report issued in April 2020

Mr A complained about accidental damage to his window caused by flying debris during crass cutting works. The window frame was damaged beyond repair and Mr A had to replace it at a cost of £685. When Mr A asked the Council to reimburse his costs, it refused to do so on the basis that it was not liable for the damage.

The Ombudsman contacted the Council and asked that it reconsider its position. Although the Council maintained that it was not liable for the damage to Mr A's window, as a gesture of goodwill, and in order to settle the complaint, it agreed to reimburse Mr A's costs.

Complaints Handling

Upheld

Hywel Dda University Health Board - Health
Case Number: 201806599 - Report issued in June 2020

Ms A complained about the care and treatment provided to her by Hywel Dda University Health Board ("the Health Board") between March 2015 and December 2016 in relation to a shoulder injury. In

particular, she complained that the care and treatment provided was not adequate and led to a delay in diagnosis of an infection in her shoulder. Ms A also complained that the Health Board's handling of her complaint was poor.

The investigation found that the treatment Ms A received following her initial presentation was adequate and without the benefit of hindsight, it was not possible to pinpoint when the infection in Ms A's shoulder may have started. However, the Ombudsman found that greater regard should have been given to Ms A's increased vulnerability to infection and that uncertainty had been caused to Ms A by inadequate clinical assessment and investigation. The investigation also found that there were unnecessary delays in the Health Board's handling of Ms A's complaint, which was likely hampered by its own misplacement of some of Ms A's medical records. The Ombudsman therefore upheld both aspects of Ms A's complaint.

The Ombudsman recommended that within 1 month of the date of the report, the Health Board should apologise to Ms A for the failings identified in this investigation and make a payment of £250 in recognition of the complaint handling failing. He also recommended that within 3 months, the Health Board should provide guidance to Emergency Department staff regarding the assessment of patients who may be more susceptible to infection.

Carmarthenshire County Council - Childrens Social Services
Case Number: 201807136 - Report issued in June 2020

Ms C complained that from July 2016 to July 2017 Carmarthenshire County Council failed to provide her with adequate support and guidance when her foster child's, D, behaviour became increasingly challenging, resulting in an incident and the end of the placement. In particular, Ms C was unhappy that the Council failed to follow correct procedures following the incident and gave her misleading advice. The Ombudsman's investigation found that the training Ms C, and her then partner Mr A, underwent before and after the placement was appropriate based on D's needs. However, the support Ms C received during this time up until the incident was concerning: Ms C's supervising social worker (SSW) did not document all his sessions with Ms C so it could not be determined whether further training was discussed or encouraged, also the SSW did not arrange for further visits prior to the incident when Ms C had indicated that the placement was difficult to manage. In addition, following the breakdown of Ms C's relationship with Mr A, the Council did not re-assess the placement and an opportunity was missed to reconsider the support and training Ms C needed. These were injustices to Ms C and the Ombudsman upheld these aspects of the complaint.

The Ombudsman also determined that the support offered to Ms C following the incident was insufficient, the Council did not fully follow child protection procedures and did not update Ms C with information from its investigations.

The Ombudsman upheld this part of Ms C's complaint as well. The Ombudsman recommended that the Council apologise to Ms C and share his report with those teams involved in Ms C's case to aid future learning. The Council agreed to implement the Ombudsman's recommendations.

Early Resolution or Voluntary Settlement

Pembrokeshire County Council - Childrens Social Services
Case Number: 202000178 – Report issued in May 2020

Miss X complained that the Council refused to progress her complaint about Children's Services to Stage 2 under its Social Services complaints procedure when requested by Miss X.

The Ombudsman found that the Council had failed to progress Miss X's complaint to Stage 2. Under the relevant regulations, it is obliged to progress complaints to Stage 2 once a request is made. In light of

the current Covid-19 pandemic, the Council agreed to carry out the following in settlement of the complaint as soon as reasonably practical and without undue delay:

1. Provide Miss X with an apology for refusing to progress her complaint to Stage 2 of the Complaints Procedure
2. Investigate Miss X's complaint under Stage 2 of the Complaints Procedure
3. Remind relevant staff of the obligation to consider similar requests under Stage 2 of the process.

Vale of Glamorgan Council - Childrens Social Services
Case Number: 201907236 – Report issued in May 2020

Mr A complained to the Ombudsman that the Council did not complete its Stage 2 Investigation into the concerns he had raised about the Council's delay in progressing a Special Guardianship Order for his grandchild, including a lack of response about backdated financial assistance. Mr A was unhappy with how the Council communicated with him, how it responded to his complaints and the impact that this had on him and his family.

The Ombudsman found that the Council acknowledged it had taken a contradictory position. It had agreed with the Stage 2 Independent Investigator's conclusion that the issues raised in Mr A's complaint had been considered in Court and therefore the investigation should cease. However, it informed the Ombudsman that backdated payments had not been determined, and that it was a decision for the Council, not the Court. Following the recommendations made in Court, Mr A attempted to seek clarification from the Council about his entitlement to backdated payments. At the time of submitting his complaint to the Ombudsman, Mr A had not received a response or an explanation.

In settlement of the complaint, the Council agreed within 10 working days, to apologise to Mr A for the lack of clarity provided to him about back payments being issued or contested in Court. Further, to apologise to Mr A for the incomplete Stage 2 complaint handling and the maladministration in the handling of his complaint. In recognition of time and trouble, the Council agreed to offer Mr A £250 financial redress, and to provide confirmation of the timeframe for processing the payment.

The Council also agreed to appoint an independent Investigator to complete the Stage 2 Investigation in its entirety. However, because of the COVID-19 situation it was not possible to set a definitive timeframe for completion.

Ceredigion County Council - Planning and Building Control
Case Number: 202000388 - Report issued in June 2020

Mrs X complained that the Council had not provided its final response in relation to her complaint, despite it repeatedly promising deadlines for a decision. Mrs X raised concerns with the Council in May 2019, regarding her neighbours' failure to adhere to planning regulations in the use of land for her business. Mrs X said that the Council initiated an investigation into the matter which has stalled on two occasions and has not been concluded.

During his enquiries, the Ombudsman established that the Council had failed to keep Mrs X adequately informed following her complaint. In settlement of Mrs X's complaint the Council agreed to complete the following:

Within 4 weeks of the Ombudsman's decision letter:

a) Provide an explanation to Mrs X as to how it dealt with her initial concern in May 2019 and to fully

explain the delays encountered by Mrs X

b) Provide an apology to Mrs X for the failure to adequately address her concerns in the Stage 1 complaint response
c) Provide an apology to Mrs X for failing to provide an update by 26 March 2020, as advised in the Stage 1 complaint response
d) Pay £50 to Mrs X for the time and trouble in bringing her complaint to the Ombudsman

As soon as possible in line with Covid-19 restrictions and without undue delay:

a) Undertake a site visit to determine the position in relation to the planning enforcement issues raised by Mrs X
b) Provide a Stage 2 complaint response.

Environment and Environmental Health

Early Resolution or Voluntary Settlement

Cardiff Council - Refuse collection. recycling and waste disposal
Case Number: 201907389 - Report issued in June 2020

Mrs X complained that the Council had, on a number of occasions, failed to collect her waste or had failed to return her bins to the agreed place, in accordance with the Assisted Lift Scheme.

The Council acknowledged the repeated failings and agreed to undertake the following in settlement of Mrs X's complaint:

a) A formal written apology to Mrs X.
b) Financial redress to Mrs X in the sum of £125, in recognition of the time and trouble to which she had been put in repeatedly complaining about this matter.
c) A commitment to monitor/audit compliance with her collection service for the next 4 months.
d) In the event of further failed collections and/or failure to return bins to the agreed position, a telephone call to be placed to Mrs X to apologise and to confirm rectification will be achieved within 24 hours.
e) In the event of further failed collections and/or failure to return bins to the agreed position, rectification within 24 hours.

The Ombudsman considered this to represent an appropriate settlement.

Housing

Upheld

Cardiff Council & Linc-Cymru Housing Association - Other
Case Number: 201902694 & 201901849 – Report issued in April 2020

Mr B, who lives in the North of England, maintained regular telephone contact with his brother-in-law, Mr A, who lived alone in a sheltered housing complex in South Wales ("the Scheme") managed by

Linc-Cymru Housing Association ("the HA"). The Scheme was fitted with a telephone alarm-call system for residents that was managed by Cardiff Council's Telecare Services ("the Service"). On 28 February **2018,** Mr B was concerned that he could not make telephone contact with Mr A and so asked the HA's Site Manager to check on him. Due to the severe weather this was not possible, but the HA requested the Service to contact Mr A via his intercom system. Mr A confirmed that he was 'ok' to the Service Operator, but sounded confused. Sadly, on 7 March, the police contacted Mr B to say that Mr A had been discovered lying dead on the floor of his living room. He had been dead for several days. Mr B complained that:

a) Mr A's death might have been prevented and/or his body might have been discovered sooner if the Site Manager and the Service Operator had acted with greater concern for his welfare.
b) A recording of the exchange between the Operator and Mr A suggested that the Operator: failed to detect or act on what Mr A had said; failed to explain the purpose of her call; failed to enquire whether Mr A required any help; and failed to pass on the message that his telephone was possibly faulty.
c) The HA failed to inform Mr B that it was treating his (and his MP's) correspondence, telephone calls and emails about the delay in discovering Mr A's body as constituting a formal complaint. The HA declined to escalate Mr B's complaint to Stage 2 of its complaint procedure.
d) Following Mr A's death, and contrary to the HA's file retention policy, HA staff inappropriately destroyed the paper file relating to his tenancy.
e) There was no evidence that the HA and the Service adopted and complied with recommendations made in the Stage 1 report and which emerged from a Safeguarding Review conducted after Mr A's death.

With regard to complaint 1, the Ombudsman found no evidence to support the complaint that Mr A's death might have been prevented if the HA and the Service Operator had acted with greater concern for his welfare. He did, however, conclude that the failure of the Site Manager to check on Mr A on her return to the Scheme, delayed the discovery of his body by at least one day. He recommended that the HA provide Mr B with a fulsome apology for this.

With regard to complaint 2, the Ombudsman upheld this complaint to the extent that the Operator could and should have engaged more fully with Mr A (beyond ascertaining that he was 'ok'). Whilst there was no evidence to suggest that the Operator was negligent or uncaring, it was not possible to exclude the possibility that Mr A might have alerted her to a problem had she engaged with him in more detail. The Ombudsman felt that this missed opportunity was an injustice to Mr B in that he will never know whether a more meaningful engagement with Mr A might have altered the subsequent course of events. The Ombudsman recommended that the Service provide Mr B with a fulsome apology for this.

With regard to complaint 3, the Ombudsman was satisfied that Mr B and his MP were informed that their correspondence would be addressed under the HA's Complaint Procedure. However, the Ombudsman concluded that there were failings in the HA's complaint-handling and Mr B's concerns should have been escalated to Stage 2 of its complaints procedure. He recommended that the HA review its procedure and, in recognition of the inconvenience to which Mr B was put as a result of these failings, that the HA should make a payment to him of £250.

The Ombudsman did not uphold complaint 4. Though critical of the HA's breach of its file-retention policy, there was no evidence that this failing caused Mr B any injustice or adversity.

Finally, the Ombudsman did not uphold complaint 5, but recommended that the HA provide evidence of how it has implemented the recommendations that followed from the Stage 1 Report and the Safeguarding Review.

Both the HA and the Service agreed to implement all of the Ombudsman's recommendations.

Early Resolution or Voluntary Settlement

Wrexham County Borough Council - Repairs and maintenance (inc dampness/improvements and alterations eg central heating. double glazing)
Case Number: 202000475 - Report issued in June 2020

Mrs X complained that the Council had categorised the repair works for cracks to her plastering as non-urgent. Mrs X also complained that the Council had informed her that she could be waiting for a year for the repair works to be undertaken.

During his enquiries the Ombudsman established that the Council had correctly categorised the repair work as non-urgent. However, the Council had failed to undertake the repair in accordance with the timeframe stipulated in its policy. In settlement of Mrs X's complaint the Council agreed to complete the following by 16 July 2020:

a) Provide an apology to Mrs X for the delay in undertaking the repairs works and for it not being completed within the timeframe stipulated in its policy
b) Provide clarification on the current situation in relation to non-urgent repair work being undertaken
c) Provide an updated timescale for when the repair work will likely be undertaken

Provide Mrs X with an explanation as to how the overdue repair work will be allocated and provide Mrs X with assurances that she will be notified before the repair work is undertaken.

NHS Independent Provider

Upheld

Pendine Park Care Organisation Ltd - Care homes
Case Number: 201807525 – Report issued in May 2020

Mrs X complained about the care given to her late husband, Mr X, at a care home run by Pendine Park Care Organisation Ltd ("the Care Organisation"). Mrs X complained that Mr X was not provided with appropriate medication; that the Care Organisation did not seek appropriate advice from health care providers; that Mr X's environment was not of a reasonable standard of hygiene and that the Care Organisation used incontinence pads for Mr X when it was not reasonable to do so. Mrs X also complained that the Care Organisation did not provide Mr X with 1 to 1 support; it did not create or retain reasonable records of the care it gave to Mr X and that it did not handle her complaints properly.

The investigation upheld Mrs X's complaint that there were a number of occasions when it did not appear that Mr X's medication had been given to him, which caused him a significant injustice. The investigation also upheld Mrs X's complaints that advice was not requested from health care providers in a timely manner on 2 occasions, and that the hygiene level of Mr X's environment was not reasonable on 1 occasion. These failings caused Mr X, who was elderly, unwell and frail, a significant injustice. The investigation found that it was appropriate and reasonable for Mr X to use incontinence products at the Care Organisation and did not uphold this complaint. It upheld the complaint that the Care Organisation did not always provide Mr X with 1 to 1 support, and it upheld Mrs X's complaint that reasonable records were not created or maintained, including her complaint that no Declaration of Liberty Safeguards

application was made by the Care Organisation on behalf of Mr X. Finally, the investigation upheld Mrs X's complaint that her complaint was not handled properly by the Care Organisation, which had lost many of Mr X's records. It found that the Care Organisation acted inappropriately by sending Mrs X a "cease and desist" letter from a solicitor in relation to her persistent complaints. This caused Mrs X an injustice, as she simply wanted to find out what had happened to her husband, and was instead threatened with legal action.

The Care Organisation agreed to apologise to Mrs X and to make a redress payment of £500 to her within 1 month. It said that it had already changed its record keeping policy and records management procedure, and had trained staff on these, but would provide copies of the policies to Mrs X. The Care Organisation said it had already reminded staff of their legal obligations under Declaration of Liberty Safeguards. It also agreed to amend its Complaints Policy to explain to persistent complainants what action it may take when it considers a complaint to be closed.

Planning and Building Control

Early Resolution or Voluntary Settlement

Powys County Council - Unauthorised development - calls for enforcement action etc
Case Number: 201907407 – Report issued in May 2020

Mr A complained that the Council had failed to carry out enforcement action against his neighbour for breaches of planning law regarding his property. He also complained about the poor communication and delays he experienced after he had complained to the Council.

The Ombudsman was unable to question the merits of the Council's decision which was taken with the use of professional judgement. Mr A was however, concerned that the Council's poor communication and delays in dealing with his complaint had continued after the Council had apologised at stage 1 of its complaint procedure.

The Ombudsman contacted the Council and it agreed to:

a) Write a letter to Mr A apologising for the further delays and poor communication following its stage 1 response to him
b) Make an offer of £150 in recognition of the time and trouble taken by Mr A in making a complaint.

This will be completed within 20 working days of the date of this decision letter.

The Ombudsman believes that this will resolve the outstanding issues in Mr A's complaint.

Roads and Transport

Upheld

Swansea Council - Parking
Case Number: 201901525 - Report issued in June 2020

Ms E complained about the way in which the Council dealt with her application for a residential parking permit, and the Council's correspondence with her following the issue of a Penalty Charge Notice ("PCN").

Ms E had recently moved into the Council's area and provided the Council with a copy of her tenancy agreement. A short time later a PCN was issued to Ms E's vehicle which was parked in a Residents' bay on Street X (where Ms E lived). Ms E's challenge to the issue of the PCN was rejected and she was given the opportunity of paying the "discount charge" of £25 within 17 days. Ms E did not do so, and the Council took enforcement action in respect of the debt, sending the relevant notices to an address in England which it had obtained from the DVLA for the registered keeper of the vehicle (Ms E). Ms E eventually paid £503 to have her car released after it was clamped by bailiffs.

The Ombudsman found that Ms E had not made a valid application for a residential parking permit, and the PCN had therefore been correctly issued. However, he concluded that, despite being obliged to send enforcement documentation to the address of the registered keeper of the vehicle, the Council should have sent copies of such documents to Ms E's Street X address, at which it knew she was living; Ms could reasonably have expected any further correspondence about the matter to be sent to that address, as the Council had written to her at that address when it rejected her challenge to the PCN.

The Ombudsman recommended an apology and reimbursement of £478 in respect of the enforcement proceedings. He also recommended action to prevent a re-occurrence of the failing, and that the Council discuss the matter with the British Parking Association.

Social Services – Adult

Not Upheld

Flintshire County Council - Services for older people
Case Number: 201807527 – Report issued in April 2020

Mrs X complained that Flintshire County Council ("the Council") failed to investigate concerns raised about the care her husband Mr X, received at a Care Home in its area in May, June and July 2017.

The investigation found that some of the concerns were medical matters and were raised in the presence of medical professionals, who were the appropriate people to take those concerns forward, if necessary. The investigation found that other concerns were addressed properly because they were raised with the appropriate person within the Council. Therefore, the complaint was **not upheld.**

Rhondda Cynon Taf County Borough Council & Treatment & Education Drug Services - Other
Case Number: 201901376 & 201902991- Report issued in June 2020

Mrs X complained about the care given to her late son Mr Y, in relation to a home detox undertaken in February 2016. Treatment and Education Drug Services ("TEDS") (a limited company and registered charity) was commissioned by Rhondda Cynon Taf County Borough Council ("the Council") on behalf of the Cwm Taf Area Planning Board to provide the Primary Care Drug & Alcohol Service ("PCDAS") in its area.

Mr Y was referred by his GP to PCDAS in January 2016 for a short-term alcohol problem. He was assessed as suitable for a home detox, which was carried out on 1 February; the detox was considered to have been a success. Sadly, Mr Y was found dead at home on 22 February, and was found to have a cocktail of drugs in his system, seemingly from the black market/street, but no alcohol.

The internal investigation of Mrs X's complaint had identified a number of failings in the process, including a failure to offer Mr Y an inpatient detox. The Ombudsman agreed with these findings. However, he concluded that the detox had been carried out safely, and that therefore Mr Y had not been caused any

injustice by any of the failings identified. He did not uphold the complaint.

Early Resolution or Voluntary Settlement

Cardiff Council - Services for People with a disability inc DFGs
Case Number: 201907112 – Report issued in May 2020

Mr X's representative complained to the Ombudsman about the care he was receiving from the Council. He was aggrieved that the Council had promised him an independent assessment of his care needs but that the assessment it had not been independent.

The Ombudsman found that whilst the Council had re-assessed Mr X's needs, that this re-assessment had been carried out by a social worker employed by the Council but who worked for a different social services team. The Ombudsman did not consider that the re-assessment was sufficiently independent of the Council.

The Council subsequently agreed that within 4 months (this extended period was deemed appropriate in view of the current Covid-19 restrictions in place) to undertake the following:

- The Council will arrange to complete an independent assessment (undertaken by someone who is not an employee of the Council) of Mr X's needs. Whilst the conclusion of the assessment is being awaited the Council will continue to support Mr X at the current level.

The Ombudsman considered this was an appropriate resolution of Mr X's complaint.

Cardiff Council - Social Care Assessment
Case Number: 202000316 - Report issued in June 2020

Ms Y complained about the delay in the Council's assessment and provision of care services for her parents. Ms Y said that the procedural failures resulted in lack of support for her and her parents. Ms Y was unhappy with the Council's complaint response because it contained inaccuracies and she was dissatisfied with the Council's findings and conclusions.

The Ombudsman contacted the Council and it explained that the department that Ms Y had complained about did not fall within the Social Services provision. Therefore it had considered Ms Y's complaint under the Corporate Complaints Policy, which does not have a second stage. The Council recognised that Ms Y may have misunderstood that she was complaining to/about Social Services.

In settlement of the complaint the Council agreed within 20 working days, to instruct a manger to review Ms Y's complaint and reconsider possible resolution.

Various Other

Early Resolution or Voluntary Settlement

Cardiff Council - Other miscellaneous
Case Number: 202000347 - Report issued in June 2020

Mrs X complained about the siting of football pitches in a park near her home and, in particular, the location of one set of goalposts right opposite her garden. She said that this had resulted in problems of damage and intrusion into her garden over a number of years. She indicated that there were other

options to configure the pitches on the field. As the current football season had ended, the Council had removed the goalposts for the summer and the immediate difficulty had been alleviated.

However, the Ombudsman noted that the problem would recur once the new football season started, and the goal posts were replaced.

The Council therefore agreed to contact Mrs X, before the start of the new football season, to arrange to meet her and discuss the new location for the pitches and goalposts, before they are marked out.