

The Ombudsman's Casebook

Issue 26 October 2016

News

Aberystwyth University Hosts Ombudsman Seminar

The Ombudsman community and stakeholders came together at a seminar at Aberystwyth University earlier this month.

The University jointly with Ombudsman Association and the International Ombudsman Institute hosted the event which looked at best practice across Europe and beyond.



Nick Bennett Elected As Director of Ombudsman Institute

The Public Services Ombudsman for Wales has been elected as a regional director of the International Ombudsman Institute (IOI).

The institute is the only cooperative organisation representing independent ombudsmen around the world.

Nick Bennett said he would use the position to make sure Wales benefits from best practice from other Ombudsman institutions across the world and he is looking forward to promoting the IOI at both a European level and globally.

Fielding Questions At The Eisteddfod

PSOW hosted a stand on this year's National Eisteddfod field, using the opportunity to raise awareness of our service and give people the opportunity to chat to staff and submit complaints in person.

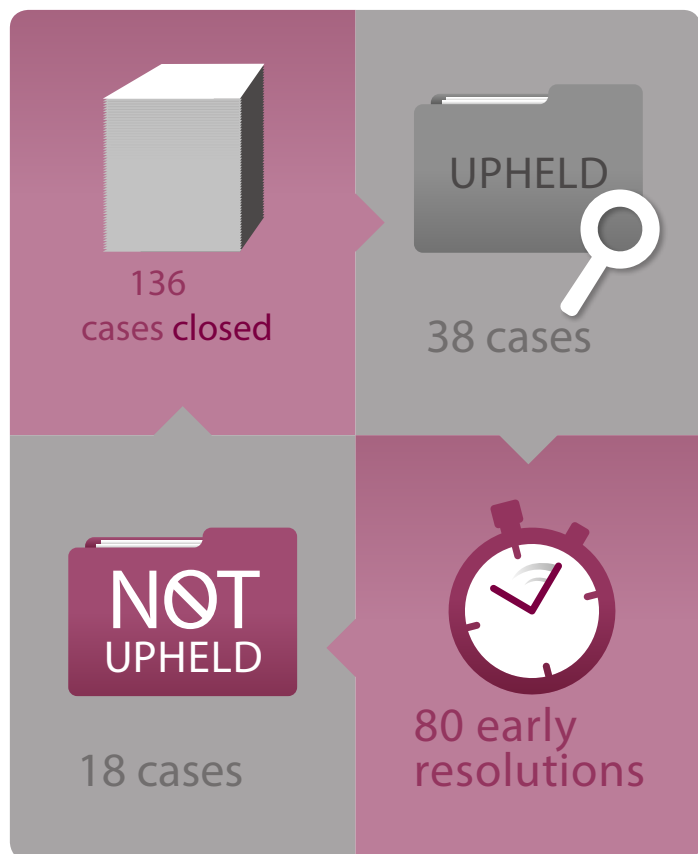
The event was attended by over 140,000 people and we saw a steady flow of visitors to the stand over the eight days.



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Casebook in numbers



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

Please note the early resolutions category also includes voluntary settlements.

Health

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

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201501406 - Report issued in August 2016

Mrs X complained about the decision not to immediately treat her husband, Mr X, in the ITU department of Glan Clwyd Hospital ("the Hospital") following his repatriation from Tenerife on 25 February 2014. She believed that, had this been the case, Mr X would have received constant monitoring and any deterioration in his condition would have been identified at the earliest opportunity, which would have given him a better chance of survival. Mrs X said that her husband was not regularly reviewed when on the renal ward. Mrs X also complained that Betsi Cadwaladr University Health Board ("the Health Board" lost Mr X's notes for six months.

Mr X suffered with Chronic Renal Failure (a long term condition where the kidneys do not work effectively) and with other medical conditions. He was a patient of the Hospital's dialysis unit and had received dialysis three times a week since around February 2012.

Mr X became ill when on holiday in Tenerife, in February 2014. On 25 February, Mr X was repatriated back to the Hospital. A fax was sent to the Hospital which detailed the treatment Mr X had received in Tenerife.

On arrival at the Hospital, Mr X was transferred to the AMU (Acute Medical Unit) department, before being transferred to the renal ward. He was not attended by a consultant until 26 February. All of the clinical renal physicians were away from the hospital that day. An ITU Registrar did not attend Mr X until 11.50am, when it was considered that Mr X may have pulmonary oedema (excess fluid in the lungs). At 1.02pm, Mr X suffered a peri-arrest (when a cardiac or respiratory arrest is imminent). The clinical plan was to increase Mr X's blood pressure so that he could have dialysis. At 9.30pm, there was a sudden deterioration in Mr X's condition and he sadly died at 10.00pm. The post mortem noted bronchopneumonia, COPD and damage caused to the kidneys due to diabetes, as the cause of death.

The Health Board carried out a Root Cause Analysis of Mr X's death. This concluded that his death was not avoidable due to his existing medical conditions and that, whilst he should have been admitted to the ITU department immediately following repatriation, this would not have saved his life. The Ombudsman's advisers found that the renal team should have been involved in Mr X's admission to the hospital, to decide when Mr X needed dialysis. They were concerned that the Consultant Physician did not instigate dialysis. The ITU Registrar also did not instigate any dialysis. Mr X was not admitted to ITU until it was too late.

The Ombudsman concluded that there was a lack of responsibility for Mr X on the part of the Consultant Physician. He was critical of the lack of renal physicians on 26 February.

The Ombudsman also noted delays in care. He said that there was a ten hour gap in observations between 10.45pm on 25 February and 9.20am on 26 February when no observations were taken. There was no attendance by a consultant between 8.00pm on 25 February and 9.00am on 26 February.

The Ombudsman was concerned about the Health Board's comments that timings in Mr X's medical records could not be relied upon, due to the practice of writing retrospectively. The most critical episode of delay, however, related to the failure to provide Mr X with dialysis. The Ombudsman found that Mr X's pneumonia would not have improved until he had received dialysis and there was no urgency for this to be done. Mr X did not receive any dialysis until 6.00pm on 26 February.

The Ombudsman was critical of the RCA and its lack of objectivity. There was no mention of fluid overload or heart failure being the major causes of Mr X's death. A further failing is the loss of Mr X's medical records for six months, without proper explanation.

Recommendations:

Renal

- a) The Health Board instigate immediate (same day) senior review of renal patient admissions by consultant renal physicians.
- b) The Health Board carry out a review of why there was no decision making renal consultant at the Hospital on 26 February, together with an explanation for inpatient responsibilities. A copy of the review should be forwarded to the Health Board's Medical Director for consideration and any appropriate action be taken within three months of the date of issue of this report. A copy should also be sent to the Ombudsman's office within this timeframe.
- c) The Health Board reminds all junior doctors and consultants working in emergency and acute medicine of the need to immediately inform renal physicians when a renal patient is admitted. Evidence should be supplied to my office that this has been completed within three months of the date of issue of this report.
- d) The Health Board's renal department draws up clear policies for the management of emergency hospital admissions of renal patients within three months of the date of issue of this report.

Governance

- a) The Health Board's Chief Executive provides confirmation to my office that the Consultant Nephrologist and the Consultant Physician have reflected upon the issues raised in this complaint, with particular reference to the themes set out in the analysis section of the report. An anonymised copy of the complaint, together with this report and the consultants' reflection on them, should be retained on their appraisal file, which will then be further discussed with their Appraiser and will be retained within the permanent appraisal database. Appropriate training should be supplied to anyone identified to be in need of it within six months of the date of issue of this report. The Health Board should also consider whether any of the issues raised as part of the process of reflection warrant referral of any relevant Consultant to the GMC.
- b) The Health Board carry out further investigation as to who was contacted by the air ambulance, the Spanish ITU department and the patient's wife. It should report the outcome of this investigation to the Ombudsman's office within three months of the date of issue of this report.
- c) The Head of the Health Board's ITU department review the delay in the attendance of the ITU Registrar on 26 February at 11.50am and provides a report to the Medical Director for consideration

containing their findings and any proposed recommendations within three months of the date of issue of this report. A copy should also be supplied to the Ombudsman's office within this timeframe.

d) The Health Board complete the work set out in the RCA regarding its review of the management of repatriated or transferred in patients as a matter of urgency. Should the Health Board decide that a policy is required to best manage repatriated or transferred in patients, that work, in addition to the review of the position, should be completed within six months of the date of issue of this report.

Apology

a) The Health Board's Chief Executive personally apologise to Mrs X for the failings identified in this report, most notably, Mr X's potentially avoidable death, within one month of the date of issue of this report.

Redress

a) In light of Mr X's potentially avoidable death, the Health Board's service failure and the uncertainty caused to the family, it should pay Mrs X the sum of £20,000, within one month of the date of issue of this report. This sum also reflects the distress caused to the family by the manner of Mr X's death, Mrs X's time and trouble in pursuing the complaint and the delayed complaint response.

OTHER REPORTS - UPHELD

Cwm Taf University Health Board – Clinical treatment outside hospital

Case Number 201501485 – Report issued in July 2016

Mrs A complained that a lack of input from community mental health teams caused a deterioration in her late husband's health, culminating in several admissions to Prince Charles and Ysbyty Cwm Cynon hospitals. Mrs A also complained about the care he received in hospital, including a dismissal of physical symptoms as being a manifestation of his dementia, poor oral care and a lack of adequate monitoring of his nutritional and hydration needs.

The Ombudsman found some failings in the level of community support for Mr A but did not conclude that this necessarily resulted in his hospitalisation. He found that, broadly, Mr A's symptoms were investigated and treated adequately, although poor record keeping left some uncertainty as to the quality of the care provided. The Ombudsman partially upheld the complaint.

The Ombudsman recommended that Cwm Taf University Health Board should:

- a) apologise
- b) take action to address the failings in recordkeeping, and
- c) share with Mrs A details of the action taken since the events complained about to address failings which it had acknowledged.

Abertawe Bro Morgannwg University Health Board – Patient list issues

Case Number 201504449 - Report issued in July 2016

Mrs X complained about the delay in her knee replacement surgery. She said the protracted wait caused a deterioration in her knees and suffering pain for longer than was necessary. The Ombudsman found that there was no clinical deterioration in Mrs X's knees during her wait. However, he found that the 90 week wait was excessive and caused avoidable adverse impact on her life.

The Ombudsman partly upheld the complaint and recommended that Abertawe Bro Morgannwg University Health Board:

- a) apologise to Mrs X, and
- b) pay her £750 in recognition of the avoidably prolonged symptoms from which she suffered.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital

Case Number 201502667 - Report issued in July 2016

Mr R complained to the Ombudsman about a delay by Abertawe Bro Morgannwg University Health Board ("the Health Board") in determining the cause of muscle wastage and pain he experienced in his shoulder and arm. He complained that as a result surgery on a cervical disc to improve his condition was delayed

for three years. He said that his condition improved following surgery. He also complained that the Health Board took too long to investigate and respond to his concerns.

The Ombudsman found there had been an unreasonable delay in diagnosing that Mr R had brachial plexus neuritis. He also found that the cervical disc operation was not necessary and that the condition, in all likelihood, would have eventually resolved on its own. The Ombudsman found however that the lack of diagnosis and consequently a prognosis coupled with external advice suggesting benefits to surgery had influenced Mr R to push for a surgical option. He was keen for surgery despite being cautioned by his surgeon that there was very little chance of the surgery being successful. The Ombudsman also found that there had been an unreasonable delay by the Health Board in responding to the complaint.

The Ombudsman upheld the complaint about the delay in diagnosing the cause of Mr R's difficulties because of the effect that the uncertainty about his recovery had on Mr R's eagerness to proceed with surgery. The Ombudsman also upheld the complaint about the manner in which the Health Board considered Mr R's concerns. He recommended that the Health Board:

- a) apologise to Mr R
- b) pay Mr R a redress of £750 and £250 for these failings respectively
- c) remind staff of the importance of discussing diagnostically challenging cases at the earliest opportunity within an appropriate multi-disciplinary forum.

Hywel Dda University Health Board – Clinical treatment in hospital Case Number 201505236 - Report issued in July 2016

Mrs L complained to the Ombudsman that Hywel Dda University Health Board ("the Health Board") had discharged her mother (Mrs M) from hospital to a care home when her condition was such that she should not have been discharged. Mrs L also complained that the Health Board had failed to inform the family about the fact that clinicians had placed a "do not attempt resuscitation" order on her mother. Mrs L also raised concerns about the manner in which the Health Board had handled her complaint about Mrs M's treatment.

Based on the available evidence, the Ombudsman found that Mrs M's discharge had been appropriate and did not uphold this aspect of the complaint. He did however find shortcomings in the manner in which the Health Board had communicated the "do not attempt resuscitation" instruction to Mrs M's family and that the Health Board had failed to respond to Mrs M's complaint in a transparent manner.

The Ombudsman upheld both of these elements of the complaint. He recommended that the Health Board:

- a) apologise to Mrs L, and
- b) pay her redress of £250.

Cardiff and Vale University LHB - Clinical treatment in hospital

Case Number 201302189 - Report issued in July 2016

Miss T complained about the treatment she received from the Emergency Department of the University Hospital of Wales, Cardiff. The complaint was investigated by the Northern Ireland Public Service Ombudsman to avoid a potential conflict of interests. Miss T complained that she was not properly assessed or diagnosed and that she was discharged home with no diagnosis or treatment. Miss T was dissatisfied with Cardiff and Vale University Local Health Board's ("the Health Board") response to her complaint.

The Ombudsman upheld the complaint, concluding that the medical and neurosurgical registrars failed to assess Miss T when they were requested to do so, that the Trauma and Orthopaedic Team failed to arrange the MRI scan and spinal surgeon referral identified as necessary, that the Board failed to diagnose Miss T's condition and provide appropriate treatment prior to discharge, and that it failed to maintain adequate records in relation to the referral to a spinal surgeon. In addition the Health Board failed to address Miss T's concerns about the referrals for an MRI scan and to the spinal surgeon and failed to provide Miss T with an explanation of the remedial action taken. During the investigation the Board did not provide adequate and timely responses to enquiries from the Ombudsman.

The Ombudsman recommended that the Health Board:

- a) apologise to Miss T
- b) provide redress totalling £2,000
- c) improve pathways for care referrals
- d) improve arrangements for MRI scan and clinic appointment
- e) improve records so that they are accurate and complete, and
- f) improve referral arrangements to specialists where patients present with rare conditions.

Cardiff and Vale University LHB - Other

Case Number 201505166 - Report issued in July 2016

Mr K complained that his mother, Mrs K, was left unsupervised and this resulted in a fall. Mr K said the circumstances surrounding this had not been adequately explained. He also complained that it was not clear whether the recommendations, which arose as a result of the investigation into the incident, had been implemented.

The Ombudsman found that, as the event was not witnessed, it was not possible to provide a more full explanation. Cardiff and Vale University LHB ("the Health Board") had conducted a thorough investigation and changes had been made to practices as a result of the lessons learned during the investigation, but this information had not been shared with Mrs K's family. The Ombudsman partially upheld the complaint. He recommended that the Health Board:

- a) write to the family providing a copy of the action plan and details of the completed action, and
- b) offer Mr K the opportunity to meet with the Health Board to discuss the action plan should he still wish to do so.

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

Case Number 201500417 – Report issued in July 2016

Mrs G was concerned that her mother (Mrs H's) condition was not taken seriously enough when she attended her GP Surgery with problems with her foot. Mrs H has type 2 diabetes. Mrs G also considered that her mother should not have been encouraged to see a private chiropodist to deal with her foot problem.

The Ombudsman found that the Surgery's actions in relation to the first two contacts with the Surgery were appropriate. However, when Mrs H attended with a red and painful foot and a black area to the tip of her big toe, the Surgery should have arranged for her to be admitted to hospital that day. The Ombudsman partly upheld this part of the complaint, while accepting that the outcome was unlikely to have been different, given that Mrs H was treated conservatively when she was admitted to hospital just over a week later.

The Ombudsman was critical of the fact that there were no records of the discussion about the chiropodist, but on balance he concluded that Mrs H was advised to see the chiropodist for routine nail care, which was acceptable. He did not uphold this part of the complaint.

The Ombudsman recommended that the Surgery:

- (a) apologise for the fact Mrs H was not admitted to hospital sooner
- (b) carry out a significant event analysis of the decision not to admit
- (c) provide evidence of how it intends to ensure its clinical records meet appropriate standards.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number 201504479 – Report issued in July 2016

Ms A complained about the length of time it had taken for her to have assessments and treatment at Wrexham Maelor Hospital following a knee injury. In particular, she complained that there was a delay of six months in an MRI scan being carried out, despite the referral being classed as urgent. She added that following the scan there was a further delay of 15 months before she underwent a surgical procedure to treat stiffness and poor knee movement.

The Ombudsman noted that waiting times for some treatment are longer than ideal. He was also mindful that the NHS has finite resources and that sometimes a patient's wait will exceed the target time. However, he concluded that based on the facts of this case the failure to offer Ms A treatment within the

timescale set out in the waiting time rules was maladministration and as a result Ms A experienced ongoing pain and distress for a significantly longer period.

The Ombudsman recommended that the Health Board:

- a) apologise to Ms A for the impact the lengthy and avoidable delay in having surgery had had on her, and
- b) pay Ms A a sum of £750 in recognition of the prolonged symptoms she had suffered as a result.

Betsi Cadwaladr University Health Board - Other Case Number 201500283 - Report issued in August 2016

Mr X had a pre-existing heart condition and travelled to Spain, because of this condition Mr X could not obtain travel insurance, but had an European Health Insurance Card ("EHIC"). He suffered a heart attack and received emergency treatment at a private hospital. Mrs X complained on behalf of her husband, that a reimbursement application for equivalent NHS cost of treatment and the request to review the decision were unreasonably rejected by Betsi Cadwaladr University Health Board ("the Health Board"). Mr X included evidence from an insurance broker that because of his condition, travel insurance could not be obtained. Mrs X said the Health Board's review process had taken too long and a National Contact Point (NCP) had not been appointed to advise with the application.

The Health Board said Mr X's emergency treatment was covered by EHIC, albeit EHIC did not allow for private treatment; it did not accept that private insurance could not be obtained for Mr X and said the care received required prior authorisation. The Health Board accepted it had not taken into account the Welsh Government's Guidance ("the Guidance") where a patient could receive European treatment in the private sector. The Ombudsman found these explanations amounted to maladministration and the complaint was upheld. The Health Board agreed to implement the following recommendations:

- a) to convene a new Panel within two months to reconsider Mr X's application
- b) apologise
- c) make a payment of £500 for a failure to properly consider the application, and
- d) notify the All Wales Working Group its document did not reflect the Guidance.

The Ombudsman did not uphold the complaint that the Health Board took too long to consider a review, nor that a NCP had not been appointed.

A GP surgery in the area of Cwm Taf Health Board – Clinical treatment outside hospital Case Number 201504203 - Report issued in August 2016

Mr M complained about the length of time it took Penygraig Surgery ("the Surgery") to refer his late wife, Mrs M, to the Royal Glamorgan Hospital ("the Hospital") for further investigations. Mr M believed that Mrs M may have received treatment to prolong her life had she been referred earlier.

An error occurred on 4 December 2013 whereby Mrs M's referral was not sent. This caused a delay of two months before she was referred to the Hospital. There was a lack of detail in Mrs M's records which made it impossible to determine with certainty whether Mrs M should have been referred to the Hospital earlier than 4 December, however there was a possibility that Mrs M should have been referred as early as 6 November. However, the Ombudsman found that, even if Mrs M had been referred on 6 November and on an urgent basis, it was very unlikely that the treatment options available to her, and ultimate outcome,

would have been different.

The Ombudsman recommended that the Surgery should:

- a) provide Mr M with an apology and redress payment
- b) remind its staff of the importance of comprehensive record keeping, and
- c) provide assurance to the Ombudsman that it will regularly review its procedure for referring patients to secondary care.

**Cardiff and Vale University Health Board - Other
Case Number 201504489 - Report issued in August 2016**

Mr X complained about Cardiff and Vale University Health Board's ("the Health Board") care and treatment of his father, Mr Y, between 12 and 13 May 2015 at Llandough Hospital. In particular, he said that the Health Board failed to explain how Mr Y had been, "left unattended and severely injured" following a fall or, why the investigation of the incident "took so long".

The Ombudsman found that there was a failure to complete the relevant documentation on admission. Had these documents been completed, it was likely that Mr Y would have had his walking stick close at hand and that he might have been placed on near constant observations. This may have meant that his fall was prevented. The Ombudsman upheld the complaints. The Ombudsman also found that the complaint investigation took too long to be completed and the upheld this complaint.

The Ombudsman recommended that the Health Board:

- a) remind staff of their obligations to complete relevant documentation
- b) apologise and calculate the financial redress that would have been due to Mr Y, had it considered the matter under the Welsh Government's 'Putting Things Right' procedure
- c) pay Mr X £250 in recognition of his time and trouble in pursuing the matter and that he should receive an apology for its complaint handling.

The Health Board agreed to implement these recommendations.

**Betsi Cadwaladr University Health Board – Patient list issues
Case Number 201506418 - Report issued in August 2016**

Mrs P complained to the Ombudsman about the length of time she had to wait to have her stoma bag removed. She understood when the stoma bag was put in place that it could be removed in six months. However, it took eleven months for the bag to be removed after her Consultant Surgeon determined that it was appropriate for this to happen.

The Ombudsman concluded that whilst Mrs P had had to wait for some eleven months for the procedure

to remove the stoma bag, there had been no clinical detriment to her as a result of having to wait for the procedure. The Ombudsman recognised however, in light of Welsh Government treatment time targets, that Mrs P had to wait longer than she could have expected to for the procedure and that this had impacted on her activities of daily living. To that extent he upheld the complaint and recommended to the Health Board that it:

- a) apologise to Mrs P, and;
- b) explain to her the measures it was taking to reduce treatment times for general surgery patients.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case Number 201505250 - Report issued in August 2016

Mrs X complained about care commissioned by Betsi Cadwaladr University Health Board (“the Health Board”) and provided by a NHS Trust in England. Mrs X complained that there had been a delay in diagnosing and treating vestibular damage, a delay in providing post operative steroids and that the post operative complications that she experienced could have been prevented. Mrs X also complained that poor practice had resulted in her requiring additional surgery.

The investigation found no evidence of a delay in diagnosing and treating Mrs X for vestibular damage. It did, however, find that Mrs X had not been provided with the relevant post operative steroids. The investigation also found that there was no evidence the post operative complications and surgery could have been prevented.

It was recommended that the Health Board apologise for the identified failings.

Betsi Cadwaladr University Health Board – Continuing Care
Case Number 201502702 - Report issued in August 2016

Mr & Mrs P complained to the Ombudsman that despite repeated requests, Betsi Cadwaladr University Health Board (“the Health Board”)’s Community Mental Health Team (CMHT) failed to provide their daughter, Ms D, with advice on how to manage medication prescribed for her condition of ADHD during the early stages of her pregnancy.

They said that the CMHT also failed to respond to a referral it received from Ms D’s GP requesting intervention and support and subsequently failed to fulfil its statutory obligation to provide Ms D with monthly consultations with a Community Psychiatric Nurse.

Mr & Mrs P described how these failings resulted in Ms D electing to stop her medication without medical supervision. This appeared to trigger a deterioration in her behaviour and, in a state of crisis, Ms D took an overdose of her medication. Mr & Mrs P suggested that this downward spiral of events might have been averted if the family’s requests for assistance and advice had been appropriately responded to.

The Ombudsman upheld Mr & Mrs P’s complaints that the CMHT failed to provide Ms D with advice about her medication and also upheld the complaint about the failure to respond to the GP’s referral. The Ombudsman did not uphold the complaint that the CMHT failed to provide monthly consultations and was

unable to say with any certainty that the downward spiral of events that led to Ms D's overdose was directly attributable to the failings that the investigation identified.

The Ombudsman recommended that the Health Board:

- a) provides an apology to Ms D for failing to provide her with support, and an apology to Mr & Mrs P for the frustration and distress that they experienced in having to make repeated requests for assistance for their daughter
- b) makes a payment of £500 to Ms D and of £250 to Mr & Mrs P, and
- c) takes steps to improve the CMHT's system of recording, logging and forwarding incoming calls, letters and emails to relevant clinicians and that the system should be periodically audited to ensure compliance.

The Health Board accepted all of these recommendations.

Cwm Taf University Health Board - Clinical treatment in hospital Case Number 201503703 - Report issued in August 2016

Mr & Mrs A complained about the care and treatment that their late son, Mr B, received at the Emergency Department (A&E) of the Royal Glamorgan Hospital. Mr & Mrs A complained that A&E clinicians were slow to recognise and respond to Mr B's symptoms of septic shock and that, by the time the life threatening nature of his condition was fully understood and acted upon, it was too late to reverse his deterioration. Sadly, Mr B passed away some five hours after his arrival at the Hospital.

The Ombudsman upheld Mr & Mrs A's complaints that:

- there were unacceptable delays in A&E clinicians assessing Mr B
- clinicians were slow to initiate the urgent intervention that Mr B's symptoms of septic shock required
- there were problems with equipment and facilities which further delayed the provision of the emergency care that Mr B required
- there were failings in the way that the Health Board dealt with Mr & Mrs A's complaint about these matters.

However, the Ombudsman could not say with any certainty that the failings he identified led to or hastened Mr B's deterioration and death.

The Ombudsman recommended that the Health Board:

- a) provide a fulsome, written apology to Mr & Mrs A and, in recognition of the additional distress to the family of having to pursue their concerns and questions about Mr B's care at a time of bereavement,

makes a payment to the family of £3,000

- b) take immediate steps to ensure that all A&E clinicians at the Hospital are able to recognise signs and symptoms of sepsis and septic shock; are able to appropriately assess patients with suspected sepsis and initiate sepsis screening; and are aware of how to escalate patients with suspected sepsis urgently
- c) implement a procedure that ensures (and records) the escalation of concerns from the reception staff to the Emergency Department Manager and which prioritises access to facilities within the Department for the most severely unwell patients, and
- d) confirm that A&E clinicians receive annual sepsis training in accordance with clinical guidelines and that it has identified medical and nursing leads for sepsis within the department.

The Health Board accepted all of these recommendations.

Cardiff and Vale University Health Board – Clinical treatment in hospital

Case Number 201502609 - Report issued in August 2016

Ms A complained about the standard of care provided to her late husband, Mr B, at University Hospital of Wales, Cardiff in 2012. The investigation considered the adequacy of Cardiff and Vale University Health Board's ("the Health Board") consideration of Ms A's complaint and concerns that Ms A had raised that Mr B's deterioration may have been caused by a streptococcus B infection.

The Ombudsman did not uphold the complaint about the streptococcus B infection as the evidence suggested that it was extremely unlikely that a streptococcus B infection was the cause of Mr B's deterioration. In relation to the Health Board's consideration of the complaint, the Ombudsman was generally satisfied that this was satisfactory and comprehensive and that appropriate action had been taken to address the failings identified. The Ombudsman did criticise the fact that the Health Board had failed to explicitly identify and address deficiencies in the nursing records relating to the provision of food and fluids and turning. To this extent only the Ombudsman partly upheld that part of the complaint. He recommended that the Health Board:

- a) apologise to Ms A, and
- b) provide evidence that the standards of record keeping on the ward concerned were now satisfactory.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number 201503862 - Report issued in August 2016

Mrs A complained about the care and treatment she received while an inpatient at Wrexham Maelor Hospital. She was dissatisfied with the care she received from the Consultant Gastroenterologist who carried out a specialist procedure to remove stones from her bile duct. She also felt that she had been inappropriately discharged. Finally, she was unhappy with Betsi Cadwaladr University Health Board's ("the Health Board") handling of her complaint.

Overall, on the evidence considered, the Ombudsman's investigation found no shortcomings in the care Mrs A received. Whilst he considered it unfortunate that Mrs A had suffered a recognised but rare complication of the procedure, she had been made aware of the risks and complications. This aspect of Mrs A's complaint was not upheld.

The Ombudsman's investigation found shortcomings in the complaint handling process and this aspect of Mrs A's complaint was upheld. He recommended that the Health Board:

- a) apologise for the failings identified
- b) make a payment of £300 in recognition of the distress caused to Mrs A, and
- c) remind its medical staff of the importance of ensuring that when blood tests are carried out they are reviewed and appropriate action taken where tests show conflicting results.

Aneurin Bevan University Health Board - Clinical treatment in hospital Case Number 201503518 - Report issued in August 2016

Mr Y complained that there were failings in the care and treatment that his late wife, Mrs Y, received at Neville Hall Hospital from July 2014. The complaint raised an important theme about the timeliness and adequacy of communication with patients and their relatives when they are dealing with very distressing and difficult events. Sadly, Mrs Y died later in 2014.

Taking account of clinical advice, the Ombudsman found nothing to suggest that any of the medical reviews had been inadequate and there was nothing to suggest that any of the discharges had been inappropriate or unsafe. The Ombudsman was also of the view that a scan had been conducted in a reasonable timeframe. He did not uphold these clinical areas of the complaint.

Mr Y also complained about the quality of the clinical recording and the general communication with Mrs Y and her family. He specifically referred to communication in respect of a Do Not Attempt Resuscitation order. To the extent of the shortcomings identified, the Ombudsman partly upheld these elements of the complaint.

Finally, in respect of Aneurin Bevan University Health Board's ("the Health Board") complaint response, the Ombudsman also partly upheld the complaint.

The Ombudsman recommended that the Health Board apologise to Mr Y, provide financial redress of £250 in light of the time and trouble incurred in pursuing the complaint, and review a specific procedure and provide further staff training.

Cardiff and Vale University LHB – Clinical treatment in hospital Case Number 201501437 - Report issued in August 2016

Mr & Mrs A complained about failings in the care and treatment that their son, Mr B, received during a brief admission to the University Hospital of Wales. Mr B, who suffered with Duchenne's muscular dystrophy (a severe muscle-wasting condition) and with cardiac and respiratory dysfunction, was admitted with a cough/

chest infection and bouts of confusion. Mr B was discharged within a few days, but, sadly, passed away at home some three days later. Mr & Mrs A complained:

- that physicians failed to appropriately manage Mr B's presenting symptoms of infection, dehydration and low blood-pressure
- that there were failings in the nursing care that Mr B received and failings in how his nursing care was recorded
- that Mr B was prematurely discharged and that failings in his care may have contributed to his sudden death.

The Ombudsman upheld Mr & Mrs A's complaint about failings in nursing care and nursing record-keeping, and was critical of one aspect of Mr B's discharge. He did not uphold the complaint about poor medical care and could find no evidence that the identified failings contributed to Mr B's sudden death.

The Ombudsman recommended that the Health Board:

- a) provide Mr & Mrs A with a fulsome apology for the identified failings in nursing care, together with a payment of £500 for the trouble the family were put to in making their complaint at a time of bereavement
- b) take steps to ensure that the nurses involved in Mr B's care adhere to Medicines Management Guidance and to guidance relating to the application of Early Warning Scoring Tools used in nursing observation
- c) implement a nursing action plan that addresses clinical and record-keeping failings; making relevant referrals to dieticians and speech and language therapists; compiling care plans; completing nutritional assessments; food and fluid-balance charts; bowel charts; falls and handling risk-assessments and weight charts
- d) remind relevant clinicians of the importance of accurately and thoroughly completing discharge documentation.

The Health Board accepted all of the Ombudsman's recommendations.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201505250 - Report issued in August 2016

Mrs X complained about care commissioned by Betsi Cadwaladr University Health Board ("the Health Board") and provided by a NHS Trust in England. Mrs X complained that there had been a delay in diagnosing and treating vestibular damage, a delay in providing post operative steroids and that the post operative complications that she experienced could have been prevented. Mrs X also complained that poor practice had resulted in her requiring additional surgery.

The Ombudsman found no evidence of a delay in diagnosing and treating Mrs X for vestibular damage. He did, however, find that Mrs X had not been provided with the relevant post operative steroids. The Ombudsman also found that there was no evidence the post operative complications and surgery could have been prevented.

The Ombudsman recommended that the Health Board apologise for the identified failings.

Aneurin Bevan University Health Board – Clinical treatment in hospital

Case Number 201505934 - Report issued in August 2016

Mrs X complained on behalf of her late aunt, Miss Y, about the care and treatment Miss Y received at Pontypool County Hospital, specifically, that there was a failure to maintain Miss Y's podiatry and hair care. Mrs X also complained that there was a failure to provide adequate physiotherapy and ensure Miss Y was seated correctly. Finally Mrs X complained that there had been a failure to adequately prepare Miss Y for discharge.

The investigation found that despite references in the records, Miss Y's toenails were overgrown and painful. Additionally, Miss Y was discharged from hospital with head lice, which had a detrimental effect on her settling into her new home.

The Ombudsman found that whilst Miss Y received regular physiotherapy, the treatment was not continued by ward staff which had affected her recovery. The Ombudsman also found that there was a failure to assess Miss Y's posture when seated which resulted in the compression of her trachea. Finally the Ombudsman found that whilst there was no communication with Mrs X regarding Miss Y's discharge planning, Miss Y's discharge was regularly discussed during multi-disciplinary team meetings.

The Ombudsman recommended that the Health Board:

- a) apologise to Mrs X for the failings identified
- b) ensure that ward staff are trained in nail cutting
- c) remind staff of the need to follow up on treatment for head lice, and
- d) remind staff of the need to ensure patients have access to the necessary equipment to support posture.

Welsh Ambulance Services NHS Trust, Aneurin Bevan University Health Board and a GP Practice in the area of Aneurin Bevan University Health Board – Clinical treatment outside hospital

Case Numbers 201504363/201504364/201504365 - Report issued in August 2016

Ms A complained about the Welsh Ambulance Services NHS Trust ("WAST"), Aneurin Bevan University Health Board ("the Health Board") and a GP ("the GP") which she said, together, led to her brother, Mr B's, death from a bowel obstruction. In brief, she said that WAST should have sent an ambulance for her brother, the GP should have examined him rather than prescribing antibiotics without seeing him, the out of hours GP ("OOHGP") should not have advised Mr B to see his GP the following day and the Health Board should have carried out a CT scan and subsequent surgery sooner than it did. Sadly, Mr B died of a cardiac arrest while being anaesthetised.

The Ombudsman partly upheld the complaint against the GP and the Health Board. It had not been

appropriate for the GP to prescribe antibiotics without examining Mr B, although the GP might not have identified the bowel obstruction and thus Mr B might not have been admitted to hospital sooner. The OOHGP should not have considered sending Mr B home, although the outcome of the consultation – that Mr B was admitted to hospital – was appropriate. The Ombudsman did not uphold the complaint against WAST, or against the Health Board in respect of inpatient treatment.

The Ombudsman recommended that:

- a) the Practice and the Health Board apologise to Ms A
- b) the Practice provide him with evidence that the training/reflection the GP had agreed to undertake had been carried out, and;
- c) the Health Board endeavour to inform the OOHGP (who was no longer employed by the Health Board) of the report.

A dental surgery in Abertawe Bro Morgannwg University Health Board area - Clinical treatment outside hospital

Case Number 201600343 – Report issued in September 2016

Miss A complained about root canal treatment (RCT) she received to her lower left second molar in March 2016. She was concerned that she developed an infection, was in pain, and ultimately had a painful extraction of the tooth.

The Ombudsman found that the decision to carry out RCT was appropriate, and the evidence suggested that it was performed in accordance with reasonable clinical practice. It was unfortunate that Miss A's tooth became worse over the following few days, but that did not in itself mean that the treatment was carried out incorrectly. The only criticism of the Practice was that further investigation of the tooth should have been carried out when she attended the Practice the day before the problem was identified.

To that limited extent only the Ombudsman partly upheld the complaint. He recommended that the Practice:

- a) apologise to Miss A
- b) offer to reimburse the cost of her treatment, and
- c) that the dentist concerned should reflect on the consultation.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case Number: 201504143 - Report issued in September 2016

Mrs M complained about the poor care and treatment that her mother received while at the Wrexham Maelor Hospital ("the Hospital"). She was unhappy that there was a delay in her mother being placed on the end of life care pathway when it was eventually recognised that her mother was not a suitable candidate for surgery. Mrs M was also dissatisfied with the decision not to operate on her mother and

the failure to adequately treat her mother's pressure sores. Additionally, Mrs M complained about clinical staff's poor communication and record keeping and Betsi Cadwaladr University Health Board's ("the Health Board") handling of her complaint.

The Ombudsman's investigation identified shortcomings in the care provided to Mrs M's mother. These included a failure to reach a decision about the surgical options available to Mrs A in a timely manner and a lack of team work by the various clinical specialities involved in Mrs A's care. This had contributed to shortcomings in communication, which were compounded by a lack of senior clinical leadership. The Ombudsman concluded that as a result of these clinical failings the quality of care Mrs A received was compromised. Administratively, the Ombudsman was also critical of the Health Board's handling of Mrs M's complaint. The Ombudsman upheld Mrs M's complaint, with the exception of the issues relating to pressure sores and record keeping where he was satisfied that the Health Board had acted appropriately.

The Ombudsman recommendations included that the Health Board:

- a) apologise to Mrs M
- b) pay her a sum of £2,000 in recognition of the distress caused to her, and
- c) discuss the Ombudsman's report at an appropriate clinical governance group with clinical staff involved in Mrs A's care.

Aneurin Bevan University Health Board – Appointments/ admissions/ discharges and transfer procedures

Case Number 201503030 – Report issued in September 2016

Ms B complained about the delay in providing restorative dentistry treatment to her father Mr D. The Ombudsman found that Mr D had been receiving treatment from a restorative dental consultant up until 2013. However, the consultant then left and Aneurin Bevan University Health Board ("the Health Board") could not recruit a replacement. It was therefore unable to provide restorative dental services to patients within its area. In 2015, it managed to offer a limited service following an agreement with the University Dental Hospital in Cardiff. Mr D was offered an appointment at the end of 2015 and underwent treatment.

The Ombudsman acknowledged that there were problems nationally in recruiting suitably qualified restorative dentists. However, there were two and a half years during which Mr D did not receive a service from the Health Board. In addition, the Health Board's response to Ms B's complaint and communication with Mr D was poor. The Ombudsman upheld the complaint and recommended that the Health Board should apologise. He was also critical of how the Health Board had responded to Ms B's complaint. The Ombudsman made no further recommendations as the Health Board confirmed that it had now recruited a restorative dental consultant.

Abertawe Bro Morgannwg University Health Board and a GP Practice in the area of Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital
Case Number 201501768/201506316 - Report issued in September 2016

Mrs B complained that her husband did not receive adequate care from Abertawe Bro Morgannwg University Health Board ("the Health Board") or the Practice before his death in December 2012. She said there was a delay in diagnosis, communication was inadequate, nursing care was poor and his discharge from hospital was not properly planned. Mrs B said the Practice did not provide proper care and prescribed excessive medication.

The complaint was partially upheld. The Ombudsman found that there was not a delay in diagnosis and appropriate treatment was planned. However, communication with Mr B and his family was not adequate there were failings in the hospital care and there was no evidence of proper discharge planning; these failings resulted in significant distress for Mr B and his family in the week before he died. The Ombudsman considered that the care provided by the GP appeared reasonable. However, recording of information was poor. He found that the Practice was unable to offer an adequate service to Mr B because of the failings by the Health Board in planning a safe discharge.

The Ombudsman recommended that the Health Board

- a) apologise to Mrs B
- b) offer £1,500 in redress for the distress caused by the failings identified, and;
- c) review a number of practices and audit its discharge procedures on the relevant ward.

The Health Board agreed to these recommendations. The GP practice agreed to introduce a new system for recording clinical contact outside the practice. All clinicians involved in the case have agreed to reflect on their involvement.

Cardiff and Vale University LHB – Clinical treatment in hospital
Case Number 201505166 - Report issued in September 2016

Mr K complained that his mother, Mrs K, was left unsupervised and this resulted in a fall. Mr K said the circumstances surrounding this had not been adequately explained. He also complained that it was not clear whether the recommendations, which arose as a result of the investigation into the incident, have been implemented.

The complaint was partially upheld. The Ombudsman found that, as the event was not witnessed, it was not possible to provide a more full explanation. Cardiff and Vale University LHB ("the Health Board") had conducted a thorough investigation and changes had been made to practices as a result of the lessons learned during the investigation, but this information had not been shared with Mrs K's family. The Health Board agreed to:

- a) write to the family providing a copy of the action plan and details of the completed actions, and
- b) offer Mr K the opportunity to meet with the Health Board to discuss the action plan should he still

wish to do so.

**Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital
Case Number 201502622 - Report issued in September 2016**

Mrs X complained about the care and treatment her late husband, Mr X, received following admission to hospital with shortness of breath. Mr X subsequently died as a result of multiple blood clots in the lung. Mrs X said that there was a failure to correctly diagnose pulmonary embolism and provide timely and appropriate treatment for that condition. The Health Board, whilst accepting that Mr X should have received such treatment, said that he would not have survived even if he had received that treatment.

The investigation found that Abertawe Bro Morgannwg University Health Board (“the Health Board”) had failed to properly investigate his condition and to treat him in a timely manner. The investigation also found that the failings had resulted in a missed opportunity to provide Mr X with timely treatment and that this affected his chance of prolonged survival. Therefore, the complaint was upheld and it was recommended that the Health Board:

- a) apologise to Mrs X, and;
- b) pay her the sum of £3,000 in recognition of the uncertainty of not knowing whether timely treatment might have changed the outcome for Mr X.

**Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number 201502943 - Report issued in September 2016**

Mrs X complained that she was not informed of the risks involved with the minor operation she had to remove a cyst from her left arm. She said that after the operation she developed keloid scarring (an overgrowth of scar tissue that develops around a wound - from which she was at an increased risk due to her dark skin) which was more painful and itchy than the cyst had been. She said that she had been told that the procedure was simple and that she would have minimal scarring, but instead the scarring was raised, itchy, painful and ugly.

Mrs X said that steroid injection treatment for the scar led to it subsiding but also left her with an unsightly scar with the skin thinned around it, so that it looked like it was constantly bruised. She said that she was self conscious and embarrassed about the scar, which was also painful to the touch. She said that her left arm was very weak, which she suspected was because of nerve damage. She said that had she known that these would have happened, she would not have gone ahead with the surgery.

The Ombudsman found that Aneurin Bevan University Health Board (“the Health Board”) could not demonstrate, because of inadequate record keeping, that informed consent had been obtained, which is maladministration. This caused Mrs X to suffer an injustice, in that she was denied the opportunity to make an informed decision about whether she should undergo the procedure which led to her having an unsightly and painful scar. The Ombudsman upheld the complaint. The Ombudsman recommended that the Health Board:

- a) apologise to Mrs X

- b) pay Mrs X £2,000 as redress, and;
- c) share the findings of the report with the clinician who undertook the procedure so that lessons could be learned.

Aneurin Bevan University Health Board – Clinical treatment in hospital
Case Number 201503249 - Report issued in September 2016

Mr X complained about the inadequate standard of medical care provided to his late mother, Mrs X, from the time of her first admission to the Royal Gwent Hospital ("the Hospital") on 17 April 2014 until July 2014 when a brain tumour was diagnosed. Mr X was aggrieved that Aneurin Bevan University Health Board ("the Health Board") initially wrongly diagnosed that his mother had suffered a stroke and treated her for that condition. Mr X was concerned that the Health Board failed to diagnose the brain tumour during that period. Mr X was also concerned that a prescription error led to his late mother taking inappropriate medication which led to her requiring urgent medical attention.

The Ombudsman found that while the initial working diagnosis of stroke after her first admission was reasonable, the Health Board should have investigated an alternative explanation for her condition after her second admission on 23 April. The appropriate radiological investigations would probably have identified that Mrs X had a brain tumour. The failure to investigate Mrs X at that stage was found to amount to service failure. This failure meant that there was a delay in properly treating her condition. While it was unlikely that the failure affected the sad outcome, the delay in treating Mrs X amounted to an injustice.

The Ombudsman upheld the complaint.

The Health Board agreed to:

- a) apologise for the failings found by the investigation, and;
- b) reflect on those failings with a view to minimising the likelihood of a recurrence.

NOT UPHELD

A Dental Practice in the area of Betsi Cadwaladr University Health Board – Clinical treatment outside hospital
Case Number 201505696 - Report issued in July 2016

Mr A complained that a Dentist failed to diagnose the cause of his toothache which led to the removal of the nerve of his tooth. During the removal of the nerve Mr A said that the Dentist injected the incorrect side of his mouth. Mr A complained that this procedure was unsuccessful and a crack developed in his tooth, which resulted in the extraction of his tooth.

The Ombudsman found that the care and treatment of Mr A's tooth was reasonable and found no evidence to suggest that he received an erroneous injection to the mouth. The Ombudsman was satisfied that the removal of Mr A's tooth was not as a result of the Dentist's actions. The Ombudsman did not uphold the complaint.

A Practice in the area of Hywel Dda University Health Board - Clinical treatment outside hospital

Case Number 201507004 - Report issued in July 2016

Mr A complained that a GP he had not previously seen in the Practice advised him to stop taking Monomil for his heart complaint to enable him to take a medication for erectile dysfunction. Mr A had visited the Practice for a prescription for a replacement for the vacuum pump he had been using, and said he did not agree with the change of treatment. Mr A complained he sustained chest pains after discontinuing Monomil, and his usual GP re-prescribed Monomil. Mr A believed that the GP's actions exposed him to the risk of further heart attacks.

The Ombudsman found that the decision to stop Monomil was reasonable; it might no longer have been required, and Mr A could have been expected to benefit from the prescription of effective medication for erectile dysfunction. The GP had advised Mr A appropriately on the risk of chest pains and what to do if this happened. The Ombudsman did not uphold the complaint.

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

Case Number 201505665 - Report issued in July 2016

Mr X complained that GPs failed to identify symptoms of the cancer from which his wife, Mrs X, later died. Mr X also complained that the GP Practice had failed to take appropriate action to address failings in care that had been acknowledged.

The Ombudsman found that, although there was evidence of a poor standard of recordkeeping, the limited clinical failings had not affected the ultimate sad outcome and the GPs had not failed to identify symptoms of cancer at an earlier stage. The Ombudsman did not uphold the complaint.

A GP practice in the Betsi Cadwaladr University Health Board area - Clinical treatment outside hospital
Case Number: 201505665 - Report issued in July 2016

Mr X complained that GPs failed to identify symptoms of the cancer from which his wife, Mrs X, later died. Mr X also complained that the GP Practice had failed to take appropriate action to address failings in care that had been acknowledged.

The Ombudsman found that, although there was evidence of a poor standard of recordkeeping, the limited clinical failings had not affected the ultimate sad outcome and the GPs had not failed to identify symptoms of cancer at an earlier stage. The Ombudsman did not uphold the complaint.

Beaumaris Health Centre - Clinical treatment outside hospital

Case Number 201505015 - Report issued in July 2016

Mrs X complained about the care and treatment her husband, Mr X, received from Beaumaris Health Centre ("the Health Centre"). Specifically, Mrs X complained that there had been a delay in referring Mr X to a dermatologist, and there had been a delay in diagnosing the malignant acral melanoma (a rare type of skin cancer) on Mr X's foot. The investigation found that given the cause and the appearance of the lesion, it was reasonable to treat it as a slow healing ulcer in the first instance.

Furthermore, the Health Centre sought advice on the lesion from both the Microbiology and Dermatology Departments, and neither mentioned melanoma. However, on the appearance of black or brown spots around the lesion, Mr X was urgently referred to a dermatologist. Finally, it was noted that it had not been possible to confirm that the lesion was a melanoma until it had been fully removed from the foot.

The Ombudsman considered that given the information available at the time, the rarity and atypical appearance of the melanoma and the inconclusive biopsy results, the time frame for diagnosis was reasonable. He did not uphold the complaint.

**Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number 201503664 - Report issued in July 2016**

Mrs C complained about the nursing care her late husband ("Mr C") received whilst a patient at Wrexham Maelor Hospital between 12 and 14 August 2014. The complaints related to the operation of medical equipment, training of staff, and information and safety briefs.

The complaints were not upheld as there was no evidence that the equipment was used inappropriately or that the patient suffered an injustice.

**Cardiff and Vale University LHB - Clinical treatment in hospital
Case Number 201505256 - Report issued in July 2016**

Mrs D complained that an Endoscopist failed to spot a tumour which she believes would have been present when she underwent a flexible sigmoidoscopy procedure (an examination of the rectum using a camera lens on a flexible tube).

The Ombudsman found that the procedure was undertaken in line with its protocol and that the management plan set out was appropriate. The Ombudsman did not uphold the complaint.

A GP Practice in the area of Cardiff and Vale University Health Board – clinical treatment outside hospital

Case Number 201600297 - Report issued in July 2016

Mrs X complained that the GP Practice had not properly diagnosed her COPD (lung disease, where there is obstruction of the lung airflow which interferes with breathing) and diabetes (the amount of glucose in the blood is too high because the body cannot use it properly). In particular, the Practice did not permit tests and investigations to be made into her condition in secondary care. Mrs X said that, had she been referred to specialists in diabetes and respiratory medicine, her heart problems would have been diagnosed and treated sooner and she would have avoided becoming critically ill.

The investigation found that the GP Practice carried out reasonable and appropriate tests and investigations, following which Mrs X was appropriately diagnosed with COPD and diabetes. The complaint was not upheld. The investigation found that there was no evidence that Mrs X made a specific request during a GP appointment for tests and investigations to be carried out in secondary care. In any event, it was reasonable and appropriate that both conditions were managed in primary care. The complaint was not upheld. There was also no evidence that even if Mrs X's conditions had been managed in secondary care, she would have received different treatment or management. Specifically, there was no evidence to suggest that her heart condition would have been diagnosed and her collapse prevented. The complaint was not upheld.

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

Case Number 201503913 - Report issued in July 2016

Mr X complained that the Practice had inappropriately removed him from its patient list. He also complained about the changes proposed or made to his medication regime by Dr Y in April 2014.

The Ombudsman found that there was no evidence that the Practice had taken steps to remove Mr X from the patient list. He did not uphold the complaint.

Dr Y had carried out an appropriate review of Mr X's heart condition, the results of which led her to conduct a medication review. This led to a reduction in Mr X's furosemide (a diuretic that prevents the body from absorbing too much salt), which was reasonable in the circumstances. Dr Y decided to refer Mr X for a review by a cardiologist. Whilst the referral itself was delayed, given that this did not result in any detriment to Mr X's treatment, the Ombudsman did not uphold the complaint.

**Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital
Case Number 201505895 - Report issued in July 2016**

Mr F complained to the Ombudsman about the standard of surgical and post-surgical care and treatment that he received at Singleton Hospital's Ophthalmology Unit following his referral there with a detached retina. Mr F complained that:

- the surgical procedure he underwent not only failed to repair his detached retina but also resulted in further loss of vision to his eye (such that his sight is now more impaired than it was before the operation)
- he was not offered the option of further corrective surgery or of any follow-up care and treatment that might improve his condition.

The Ombudsman did not uphold either of Mr D's complaints. Drawing on clinical advice that he commissioned, the Ombudsman concluded that Mr F's retina was correctly repaired but that his loss of vision was due to a rare post-operative blockage (or occlusion) in a retinal vein. There was no evidence to suggest that this unfortunate occurrence was due to the surgeon's performance of the operation or to any failing in the care and treatment that Mr F received. The Ombudsman also found no evidence of any post-operative failure to offer Mr F further intervention or treatment that might have corrected or improved his loss of vision.

**Oasis Healthcare Ltd. - Clinical treatment outside hospital
Case Number 201505374 - Report issued in July 2016**

Mrs X complained about the care and treatment her son, Z, received from Oasis Healthcare Ltd. Specifically, Mrs X said that the fixed braces on Z's teeth had been removed too soon and as a result Z's teeth had moved.

The Ombudsman found no evidence to suggest that the removal of Z's fixed braces in November 2011 caused a relapse in his teeth therefore the complaint was upheld.

The Ombudsman did recognise that there was no evidence that the Orthodontist had provided Z with information relating to the consequences of not wearing his retainers and reminded the Orthodontist of the importance of providing such information to future patients and documenting that the information provided.

**Hywel Dda University Health Board – Clinical treatment in hospital
Case Number 201506756 - Report issued in July 2016**

Mr X complained that he suffered a perforated bowel as a result of an endoscopic procedure. He complained that the risks had not been adequately explained to him.

The Ombudsman found that Mr X had undergone an appropriate consent procedure, which outlined the risks. He found that perforation was a recognised risk and there was no evidence of any clinical shortcomings which would have caused the perforation. The Ombudsman did not uphold the complaint.

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

Case Number 201505875 - Report issued in July 2016

Mr A's complaint related to the care and treatment he received from a GP during the two consultations he had with him in November and December 2015. Mr A said that the GP did not show an appropriate level of care and concern for his well-being. Mr A said that during the consultation in November the GP showed little interest and prescribed medication that he was already taking. As a result, Mr A said that he was prescribed excess diazepam. Mr A said that during the consultation in December the GP failed to refer him on a priority basis for a mental health assessment.

The Ombudsman's investigation concluded that overall, the care that Mr A received was reasonable and appropriate and found no basis on which to criticise the GP's management of Mr A. Mr A's complaint was therefore not upheld.

Aneurin Bevan University Health Board – Clinical treatment in hospital

Case Number 201503120 – Report issued in September 2016

Mrs X's complaint concerned many aspects of Aneurin Bevan University Health Board's ("the Health Board") nursing care provided to her late father Mr Y whilst he was on its dementia ward. Mrs X said the dementia ward was not a suitable environment for Mr Y as he was less impaired, in terms of insight, than other patients on that ward. Mrs X complained that Mr Y's dementia and his overall physical and mental condition deteriorated whilst on the ward, and ultimately led to his premature death.

The investigation concluded that Mr Y was regularly reviewed, monitored, evaluated, appropriate interventions instigated and follow up provided. Further Mr Y's clinical records reflected the good standard of care he received which was within reasonable clinical practice and guidance. The investigation found that the dementia ward was the most suitable environment for Mr Y's specific needs to be addressed by staff.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case Number 201600257 - Report issued in September 2016

Mrs C complained about the manner in which Betsi Cadwaladr University Health Board ("the Health Board") had dealt with her complaint. In particular she was concerned about how a complaint resolution meeting had been arranged and conducted and that she was asked to provide specific questions for staff before the meeting.

The Ombudsman found that there were some areas for improvement in the process. However, the lack of resolution to the complaint did not result from deficiencies in the complaint responses or the complaint meeting. He did not uphold the complaint.

Whilst acknowledging that it is often of benefit to clarify areas for discussion prior to complaint resolution meetings, the Ombudsman suggested that the Health Board should consider whether it is helpful to approach complainants for specific questions for members of staff before complaint resolution meetings, and how these are then used before and during the meeting. In addition, recording complaint resolution meetings should be considered. The Health Board confirmed that it now routinely offers to record complaint resolution meetings and provides a copy of the recording to the complainant.

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

Case Number 201507002 - Report issued in September 2016

Mr X complained to the Ombudsman that his GP had failed to arrange an ambulance to take him to hospital to attend the Rapid Assessment Unit ("the Unit") at his nearest hospital. Mr X complained that the GP did not take account of his overall health and the fact that he had recently been discharged from hospital following cardiac surgery. Having walked home from the surgery, Mr X then blacked out and was taken to hospital by ambulance. He remained in hospital over that weekend.

The Ombudsman found however that there had been no indication for the GP to have arranged for an ambulance to take Mr X to the Unit and that the GP could not have predicted Mr X's subsequent collapse based on the evidence available. The GP acknowledged that he could have provided Mr X with a better explanation at the time of why he needed to attend the Unit and that an ambulance transfer was not necessary. However given this acknowledgement and that the decision not to call an ambulance for Mr X was reasonable, the Ombudsman did not uphold the complaint.

Cardiff and Vale University Health Board - Clinical treatment in hospital

Case Number 201507094 - Report issued in September 2016

Mr M complained about a biopsy procedure carried out in September 2014. He was concerned, in particular, about the consenting process and the procedure itself, given that he suffered bleeding at the operation site which resulted in him suffering a stroke. He was also concerned that the procedure was unnecessary and that he would have received the same treatment without it.

The Ombudsman found that the records showed that Mr M had been advised of the potential risks arising from the surgery and his signature on the consent form documented his acceptance of those risks. He also concluded that the procedure had been carried out to an adequate standard. He found the bleed that occurred was not unusual for the type of procedure and there was no indication that it occurred as a result of sub-standard treatment. He also concluded that to establish a clear diagnosis and suitable treatment options, the biopsy procedure was appropriate and necessary. He did not uphold Mr M's complaint.

Cardiff and Vale University LHB - Clinical treatment in hospital

Case Number 201505380 - Report issued in September 2016

A support worker complained to the Ombudsman on behalf of Mr A. He said that Mr A, because of his limited understanding of English, did not understand the nature of planned toe surgery, and also that the procedure was not carried out competently.

The Ombudsman found nothing in the records to suggest that Mr A had informed members of staff of any communication difficulties, or expressed any concern about signing the consent form. The surgery was carried out to a reasonable standard. He did not uphold the complaint.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital

Case Number 201505337 - Report issued in September 2016

Ms X complained about the treatment her father received at Morriston Hospital. She said blood-thinning medication was not given, which resulted in a clot in his lung.

The Ombudsman found the decision to withhold blood-thinning medication was acceptable and was taken having considered the risk of bleeding during surgery. The Ombudsman did not uphold the complaint.

EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

Hywel Dda University Health Board - Clinical treatment in hospital Case Number 201506564 - Report issued in July 2016

Mrs B complained that her late father's care was adversely affected by a failure to sufficiently consider his symptoms, which led to a delay in his diagnosis and treatment. Mrs B also said that Hywel Dda University Health Board ("the Health Board") had delayed in responding to her complaint and postponed the opportunity to meet and discuss her concerns.

The Ombudsman considered that the Health Board had not completed its consideration of Mrs B's concerns and concluded that it would be appropriate to settle her complaint. The Health Board agreed to:

- a) provide Mrs B with a written apology for the delays she experienced in raising her concerns with the Health Board
- b) provide Mrs B with a payment of £500 in recognition of these delays , and
- c) engage an independent expert to review Mrs B's complaint and provide her with a response within three months, and take steps towards and/or implement any recommendations within a further month.

Aneurin Bevan University Health Board - Clinical treatment outside hospital Case Number 201505824 - Report issued in July 2016

Mr Y complained that the Community Mental Health Team (CMHT) failed to provide him with adequate care and support from January 2015, when a care and treatment plan was put in place. Mr Y said that his mental health condition had not been properly diagnosed and that he has not been followed up as required. Mr Y also complained that the agreed actions following Aneurin Bevan University Health Board's ("the Health Board") complaint investigation had not been adhered to. The Health Board had already recognised some shortcomings in Mr Y's care and treatment and it offered a settlement in light of these.

The Health Board agreed to:

- a) provide a letter of apology
- b) offer a redress payment of £750 in light of the shortcomings and time and trouble incurred for Mr Y in making the complaint, and
- c) arrange a referral to an attention deficit hyperactivity disorder (ADHD) clinician to assist in the process of diagnosis.

The Ombudsman has also brought to the Health Board's attention a number of areas for it to consider in future practice.

A GP Practice in the area of Aneurin Bevan Health Board - Clinical treatment outside hospital Case Number 201601416 - Report issued in July 2016

Mr X complained about the manner in which his requests, both for information and to make a complaint, were dealt with. He also complained about the delay in diagnosing his medical condition. Mr X said that he had not received a full response to his complaint from the GP Practice.

The GP Practice agreed to:

- a) provide a full response to both issues raised in Mr X's complaint
- b) provide a full response within 30 working days, and
- c) provide a copy of the response to the Ombudsman's office.

**Wrexham County Borough Council & Betsi Cadwaladr University Health Board
Case Number 201503814/5 - Report issued in July 2016**

Mrs D complained that the Community Mental Health Team (which is jointly run by Wrexham County Borough Council ("the Council") and Betsi Cadwaladr University Health Board ("the Health Board")) had not adequately assessed her and withheld two hours of Direct Payments which had previously been agreed.

The Ombudsman found that whilst there had been some issues with the way the Council and the Health Board had dealt with this case, many of the issues had been addressed during the complaints process and the current assessments were appropriate. However, for a period of time in 2015, the Council had not adequately recorded its decision making process when reducing the number of hours of direct payments Mrs D would receive, or kept Mrs D properly informed.

The Council agreed to:

- a) pay Mrs D the equivalent of two hours per week for one year which amounted to £755.04, and
- b) amend its process to ensure that service users with mental health problems are informed about local advocacy services.

**Hywel Dda University Health Board – Clinical treatment in hospital
Case Number 201601486 – Report issued in July 2016**

Ms A complained to the Ombudsman because she had serious concerns about the level of communication from Hywel Dda University Health Board ("the Health Board") after making a complaint in January 2016.

Ms A was disappointed that the Health Board had failed to provide her with a copy of full medical records six months later or any updates on the progress of the complaint.

The Health Board identified the cause of the delay and agreed to take the following actions:

- a) a senior manager would personally contact Ms A to offer a meaningful apology
- b) provide Ms A with a progress report by 5 August
- c) expedite its investigation to provide a conclusion as soon as possible.

**Cwm Taf University Health Board - Clinical treatment in hospital
Case Number 201601282 – Report issued in July 2016**

A complaint was made to Cwm Taf University Health Board ("the Health Board") in September 2014. This was in relation to a delay in diagnosing cancer of the clavicle between January 2014 and April 2014. After receiving a response to the complaint, Ms X raised further concerns which required further clarification. The Health Board's response was outstanding.

The Health Board was contacted and it has agreed to undertake the following in settlement of the complaint:

- a) provide a written response to the further concerns in Ms X's letter on 15 October 2015.

**Hywel Dda University Health Board – Clinical treatment in hospital
Case Number 201601328 – Report issued in July 2016**

Mrs X complained to Hywel Dda University Health Board ("the Health Board") in December 2015 regarding the care and treatment her late husband received at both Worthybush Hospital and Glangwilli Hospital. At the time of submitting the complaint to the Ombudsman, the Health Board's response remained outstanding.

The Health Board was contacted and agreed to provide Mrs X with its full response by 27 July 2016 along with an apology for the time taken to provide Mrs X with its response.

**Abertawe Bro Morgannwg University Health Board – Patient list issues
Case Number 201601655 – Report issued in July 2016**

Mrs B complained that due to Abertawe Bro Morgannwg University Health Board's ("the Health Board") administrative error, she was not placed on the waiting list for a hernia operation, which she still awaits.

The Ombudsman found that the Health Board was yet to provide Mrs B with a written response to her complaint. The Health Board agreed to provide Mrs B with a formal written response within seven weeks.

**Cwm Taf University Health Board - Health - Clinical treatment in hospital
Case Number 201600993 – Report issued in July 2016**

Mrs X experienced an adverse reaction to the morphine she was administered when she was taken to the Prince Charles Hospital ("the hospital") with a suspected angina attack. Mrs X complained that the reasons for her reaction were not explained at the time and also not recorded in her clinical notes. The Ombudsman found that this reaction – vaso-vagal syncope (fainting), should be recorded in a patient's clinical notes in line with General Medical Council guidance.

There were no failings identified in relation to the clinical care that Ms X received. The Health Board agreed to:

- a) issue a reminder to all relevant staff that vaso-vagal syncope (fainting) should be recorded in a patient's clinical notes within 1 month of receipt of the decision letter.

**Hywel Dda University Health Board - Clinical treatment in hospital
Case Number 201601292 – Report issued in July 2016**

Mr and Mrs A brought a complaint against Hywel Dda University Health Board ("the Health Board") in relation to the delay in its investigation into the care and treatment their son received.

It was apparent from the information available that the Health Board had failed to provide a full response, despite previous assurances that one would be sent, and failed to keep them updated.

The Health Board agreed to undertake the following by 16 August 2016:

- a) provide an apology with a full explanation for the delays
- b) provide a full response to the concerns raised
- c) offer a time and trouble settlement for the delays and lack of updates

**Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number 201505109 - Report issued in July 2016**

Mr D complained about the standard of care provided to him concerning a referral for hip replacement surgery. He was referred initially in 2010 for a right hip replacement, but did not proceed with this as his hip pain had subsided. He was re-referred with hip pain in 2014, and went through the pre-operative assessment process. On the day of surgery, it transpired that he had been scheduled for a right hip replacement, when the pain that he was experiencing was in his left hip. The operation was cancelled. Mr D complained about the stress and inconvenience of the whole process and of attending unnecessary appointments.

The Ombudsman found that the referral for a right hip replacement in 2010 was entirely appropriate as there was clinical evidence of osteoarthritis in the right hip. Following the second referral in 2014, the records showed a lack of clarity as to which hip was to be operated on, which was only discovered on the day of surgery. This was unacceptable. The record keeping was of a poor standard which had contributed to the error. Aneurin Bevan University Health Board agreed to:

- a) apologise to Mr D, and
- b) to make a financial payment to him of £625 in recognition of the inconvenience and stress involved in attending various pre-operative appointments unnecessarily.

Cardiff and Vale University LHB - Appointments/admissions/discharge and transfer procedures

Case Number 201601630- Report issued in July 2016

Mrs S complained to the Ombudsman that following a referral in 2014 to a specialist surgeon outside Cardiff and Vale University LHB ("the Health Board") area, she had not received an appointment to see that consultant. Furthermore, the Health Board could not provide her with any indication of when she would receive an appointment to see the Consultant. Upon enquiring with the Health Board, the Ombudsman was told that the delay in referring Mrs S arose as a result of a failure to follow the correct funding process for the referral.

The Health Board agreed to apologise to Mrs S and pay her redress of £250 for the delay in receiving the appointment. It has also arranged for Mrs S to receive an appointment to see the specialist consultant within one week. The Ombudsman considered that this action was appropriate to settle the complaint.

Powys Teaching Health Board – Continuing Care

Case Number 201600342 - Report issued in July 2016

Mr D's representative ("the representative") complained about the manner in which Powys Teaching Health Board ("the Health Board") had dealt with his retrospective claim for reimbursement of his late mother's

(Mrs F) Continuing Health Care (CHC) costs. The concerns raised included discrepancies between the needs assessment document prepared by one of the Health Board's clinical assessors and the decision of the Special Review Panel convened to consider Mrs F's eligibility.

Enquiries by the Ombudsman identified that two different needs assessment documents had been prepared and that the document provided to the representative differed in a number of aspects from the document that the Panel relied upon to arrive at its decision. Since the discrepancies between the two documents cast doubt upon the validity of the decision making process in this case, the Health Board agreed to arrange for another clinical assessor to prepare a fresh needs assessment document and for Mr D and the representative to be given the opportunity to consider the recommendation of the new assessment in accordance with the Health Board's procedures.

**Hywel Dda University Health Board - Clinical treatment in hospital
Case Number 201601772 - Report issued in July 2016**

Mr Y complained about the care and treatment that his late father received at Glangwili General Hospital. Mr Y said that his father was inappropriately discharged from hospital on 15 April 2014, which led to him requiring a further hospital admission a few days later. Sadly Mr Y's father died shortly following this second admission.

Mr Y also said that Hywel Dda University Health Board's ("the Health Board") management of his complaint had been unsatisfactory. The Health Board agreed a number of actions in settlement of the complaint. It agreed to provide:

- a) an apology which fully recognises the shortcomings which occurred during the discharge process for Mr Y's late father
- b) an apology for the complaint handling, particularly the excessive delays
- c) a financial redress payment of £500 in recognition of the shortfalls
- d) evidence of improvements put in place since Mr Y's late father's discharge.

**Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital
Case Number 201602058 - Report issued in July 2016**

Mrs M said that in 2010 she was told that she needed a hysterectomy as she had an abnormal growth in her right ovary. More recently, she had been told that she had borderline cancer. Mrs M's complaint concerned poor communication and Abertawe Bro Morgannwg University Health Board's ("the Health Board") failure to carry out a hysterectomy sooner as it wanted to ensure she had completed her family.

The Ombudsman stressed to Mrs M that in a meeting she was having with the Health Board's clinicians she needed to fully set out her reasons for wanting a hysterectomy sooner. Mrs M later confirmed that the Health Board had given her an explanation about her condition and offered her a hysterectomy.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case Number: 201602806 - Report issued in July 2016

Mr A with the assistance of his CHC adviser complained about unreasonable delays on the part of Betsi Cadwaladr University Health Board ("the Health Board") in responding to concerns raised about the care and treatment provided to his late wife in 2012-2013. Mr W complained in November 2014; a response was received in September 2015. Further concerns were raised in March 2016 a response is yet to be received.

Having considered the complaint the Ombudsman contacted the Health Board who agreed that there had been two periods of long delay in the provision of the complaint responses to Mr A. In recognition of this the Health Board agreed that it would:

- a) respond to Mr A's further concerns
- b) provide a meaningful apology to Mr A recognising the delays experienced
- c) make a payment of £250 in recognition of time and trouble taken to pursue these concerns.

Powys Teaching Health Board and Abertawe Bro Morgannwg University Health Board – Continuing Care

Case Numbers 201602407 & 201602408 - Report issued in August 2016

A firm of solicitors ("the Firm") acting for the estate of the late Mrs X, who had been a resident of a care home when she died, had submitted a claim for retrospective NHS Continuing Health Care funding ("CHC") to Powys Teaching Health Board ("the first Health Board"), which administers the claim process. As was required, the Firm had submitted certain evidence it said demonstrated Mrs X had paid for her care for the period for which CHC was now to be claimed. This had to be provided in advance, by a cut off date. If deemed eligible for CHC, payment would then be reimbursed by Abertawe Bro Morgannwg University Health Board ("the second Health Board"). The Firm complained about the decision taken by first Health Board, and the second Health Board, to reject the claim on the (apparent) ground that appropriate payment evidence had not been submitted by the cut off date, and so its file was closed. The Firm argued that its decision was wrong in that relevant evidence had been provided, demonstrating that Mrs X paid for her care throughout the period.

On reviewing the evidence, the Ombudsman considered that the letter issued by the first Health Board was deficient in its reasoning for rejecting the claim; failing to explain why, or what, evidence was insufficient (instead only quoting a general paragraph from Welsh Government Guidance about claim evidence).

Having examined the actual evidence sent to him, it was also clear, in the Ombudsman's opinion, that payment for the period was clearly demonstrated. Accordingly, the Ombudsman invited first Health Board and the second Health Board to agree to settle the case on the basis of either issuing a fresh decision with full reasons, or to accept the evidence as presented as sufficient to proceed to consider CHC eligibility. Both the first and second Health Boards indicated that the Firm had not provided them with all the payment evidence, as now forwarded by the Ombudsman, at the relevant time. Both agreed to:

- a) accept the payment evidence as submitted by the Ombudsman as sufficient, and;
- b) re-open the case to proceed to determine any CHC eligibility in the usual way.

**A GP practice in the area of Hywel Dda Health Board - Clinical treatment outside hospital
Case Number 201601566 - Report issued in August 2016**

Mrs A raised a concern about the GP practice ("the Practice") in relation to its lack of response to a complaint she raised in April 2016.

On receipt of the complaint the Ombudsman contacted the Practice which confirmed that it wrote to Mrs A in May 2016 with an offer of a meeting; however this had not been utilised. The Practice confirmed that it failed to follow up a response in writing.

The Practice agreed to provide Mrs A with a response to her concerns by 22 August 2016.

**Abertawe Bro Morgannwg University Health Board – Clinical treatment outside hospital
Case Number 201601016 - Report issued in August 2016**

Mr R complained that Abertawe Bro Morgannwg University Health Board ("the Health Board") had failed to provide him with an independent psychological assessment of his condition. He was dissatisfied that this had been carried out by staff at the Caswell clinic, which was within the authority of the Health Board. He felt that staff at the clinic were reluctant to record a diagnosis of severe Autism/Asperger's as this may affect a decision on funding his care and treatment.

The Ombudsman was of the opinion that Mr R should be provided with the opportunity for an independent assessment. The Health Board agreed to:

- a) arrange for an independent psychological assessment to be carried out by a psychiatrist who is not employed by the board
- b) source an appropriate independent individual within 20 working days of the date of my decision letter
- c) arrange an appointment for the complainant's assessment with 40 working days of my letter, and
- d) provide the complainant (or his representative) with a copy of the assessment report within a further 40 working days of the completion date of the assessment.

**A GP surgery in the area of Betsi Cadwaladr Health Board - Other
Case Number 201601425 - Report issued in August 2016**

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

Upon receipt of the complaint the Ombudsman contacted the Surgery which agreed to:

- a) write to Mrs P and invite her to a local resolution meeting with the GPs in order to seek a way forward for her continued treatment

- b) offer her two dates for the meeting within 20 working days of the date of its letter to her.

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

Case Number 201602947 - Report issued in August 2016

Mrs C complained that her late mother's GP failed to visit her at her home in a timely manner. In fact, it took over eight hours to respond. She also complained that the GP practice failed to respond to her complaint within 30 days, as indicated in the 'putting things right' document.

Having considered the complaint, it was apparent to the Ombudsman that the GP practice had responded to the complainant, but had not included much detail of actions it had taken to improve its service. The GP practice agreed to write a further letter to the complainant outlining the actions it had taken as result of reviewing the circumstances surrounding her complaint.

Abertawe Bro Morgannwg University Health Board – Other

Case Number 201602350 – Report issued in September 2016

Mr and Mrs H complained that hospital staff referred them to Social Services referencing a concern around the handling of their newborn baby. However, staff made the referral without discussing their concerns with them or informing them of the referral before it was made.

The Ombudsman found that in its complaint response Abertawe Bro Morgannwg University Health Board ("the Health Board") did not address Mr and Mrs H's concerns adequately and failed to explain the circumstances around the referral or the evidence on which it was based.

The Health Board agreed to undertake the following actions to resolve the complaint:

- a) apologise for the failure to address these issues within the complaint responses
- b) provide a full explanation and response to your outstanding concern, and;
- c) complete these actions no later than 30 September 2016.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital

Case Number 201602456 - Report issued in September 2016

Mrs X complained about the standard of care received by her late partner Mr Y who sadly passed away in July 2015. Mrs X wrote to the Chief Executive in August 2015. Abertawe Bro Morgannwg University Health Board ("the Health Board") failed to provide Mrs X with its final response in relation to redress, and fully answer the issues Mrs X originally raised.

The Health Board apologised for not keeping Mrs X up to date with progress of the redress claim and assured the Ombudsman that an update would be sent to Mrs X imminently. The Health Board also agreed to keep Mrs X updated regularly with the progress of the situation.

Hywel Dda University Health Board - Clinical treatment in hospital

Case Number 201602521- Report issued in September 2016

Mrs X complained about treatment she received at Glangwili General Hospital in November 2014. Since making her original complaint to Hywel Dda University Health Board ("the Health Board") in November 2015, Mrs X had yet to receive a final response.

The Ombudsman contacted the Health Board which apologised for the delay in responding. It agreed to prepare the complaint response expeditiously, once the requested records had been received. It would also continue to keep Mrs X informed of the progress.

Aneurin Bevan University Health Board - Clinical treatment in hospital

Case Number 201602833 – Report issued in September 2016

Mr X's complaint related to the treatment received by his mother whilst under the care of Aneurin Bevan University Health Board ("the Health Board") from 29 September 2015 and 2 October 2015. Although Mr X put his concerns to the Health Board a number of months ago, the final response remained outstanding.

The Health Board were contacted and it agreed to undertake the following in settlement of Mr X's complaint:

- a) apologise for the delay in providing its final response
- b) provide its final response by 17 October 2016.

A GP surgery in Betsi Cadwaladr University Health Board – Other

Case Number 201601425 – Report issued in September 2016

Mrs P complained that a Doctor at the surgery she attended had behaved in a dismissive manner towards her during a consultation with her on 4 February 2016. She was experiencing problems with sleeping due to her condition and she felt that the Doctor showed no empathy towards her by suggesting that she should take up yoga and walking.

She also raised a concern that the Doctor prescribed Citalopram for her to take. She believed that medical guidelines state that this should not be taken alongside Duloxetine.

Upon receipt of the complaint the Ombudsman contacted the surgery which agreed to:

- a) write to the complainant and invite her to a local resolution meeting with the Doctors in order to seek a way forward for her continued treatment
- b) offer her two dates for the meeting within 20 working days of the date of its letter to her.

NHS Independent Provider in Abertawe Bro Morgannwg University Health Board - Out of Hours - Community Based Services

Case Number 201603293 – Report issued in September 2016

Ms T complained that an out of hours general practitioner had failed to consider her previous medical history during a telephone consultation on 7 May 2016. This resulted in her not being prescribed antibiotics for her suspected tonsillitis. She was of the opinion that this had caused a 'flare up' of an ongoing Psoriasis condition that she suffers with.

She also complained of being unhappy that she was not offered a 'face to face' meeting at the consultation or complaint investigation stage.

Abertawe Bro Morgannwg University Health Board was contacted and it has agreed to write to Ms T:

- a) apologising for the apparent lack of communication thus far
- b) Offering her an opportunity to attend a local resolution meeting with relevant staff.

The offer of a local resolution meeting will be made within 10 days of this decision letter and the offer dates within 20 working days thereafter.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital

Case Number 201603164 – Report issued in September 2016

Mr X complained about an eight month delay in Abertawe Bro Morgannwg University Health Board ("the Health Board") informing him that his complaint was out of time for investigation.

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

- a) to provide Mr X with an apology for the eight month delay in responding to his complaint
- b) to provide an explanation for the eight month delay.

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

Abertawe Bro Morgannwg University Health Board – Other

Case Number 201603213 – Report issued in September 2016

Mrs A complained that Abertawe Bro Morgannwg University Health Board ("the Health Board") had failed to inform her of its decision following an assessment undertaken by her daughter in July 2015. Furthermore, Mrs A had complained about the lack of communication to the Health Board in July 2016 and had failed to receive a response.

To settle the complaint, the Health Board agreed to:

- a) provide its response to the complaint made to it in July 2016 by 30 September 2016
- b) pay £250 to Mrs A for the time and trouble of making the complaint.

**Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case Number 201603421 – Report issued in September 2016**

Mr X complained that, following a circumcision and insertion of a semi-rigid penile implant at the end of February 2015, he lost several inches from his penis.

The Ombudsman considered that the Health Board's response to Mr X was not adequate. The Health Board agreed to:

- a) provide an appropriate investigation response to Mr X by 31 October 2016.
- b) apologise for the way in which it has handled Mr X's complaint, and
- c) provide a payment of £100 to Mr X for the time and trouble in making his complaint to the Ombudsman.

**Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital
Case Number 201602804 – Report issued in September 2016**

Mr X raised concerns after his daughter passed away following a biopsy to determine a diagnosis for shortness of breath experienced after some heavy physical activities.

Mr X said that after the biopsy, his daughter's health seriously deteriorated, she became moribund and dependent on supplementary oxygen. He complained that the risks involved and the high mortality rate associated with the procedure was not explained to his daughter prior to the procedure and she had expressed that had she been aware of the risks she would not have agreed to the procedure. Mr X's daughter passed away eight days after the procedure.

The Ombudsman's office noted that Mr X, and his grandson, attended a meeting with the Health Board but no formal decision in writing had been received. His office therefore contacted the Health Board and it agreed to send a written response outlining what was discussed in the meeting and the outcome.

Mr X was advised that if he is not satisfied with the Health Board's outcome he could bring his complaint back to the Ombudsman.

**A GP Practice ("the Practice") in the area of Abertawe Bro Morgannwg University Health Board
– clinical treatment outside hospital**

Case Number 201601936 - Report issued in September 2016

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

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

- a) apologise to Mrs X for how it handled her complaint and for suggesting that the patient should

register elsewhere

- b) review the Practice's complaints procedure to ensure it complies with relevant regulations and guidance
- c) review the Practice's patient removal policy to ensure it complies with relevant regulations and professional guidance
- d) train relevant staff on the revised complaints procedure and patient removal policy.

**Cardiff and Vale University Health Board – Clinical treatment in hospital
Case Number 201601771 - Report issued in September 2016**

Mrs X complained on behalf of her daughter (Mrs Y) about the care and treatment that Mrs Y received during her pregnancy and stay at the University Hospital Wales. Mrs X also expressed concern about Cardiff and Vale University Health Board's ("the Health Board") subsequent complaint response.

The Health Board agreed a number of actions in settlement of the complaint. It agreed that:

- a) an entry be made to Mrs Y's medical records indicating the need for a caesarean section in future pregnancies, and
- b) a letter be sent to Mrs Y and copied to her GP outlining the above agreement.

The Health Board confirmed that details would then be held on the electronic file, medical records and a copy of the agreement would be with Mrs Y and stored on her GP record. The Health Board said this would support the agreed action taking place.

The Ombudsman taking account of the complainant's view decided that this was a reasonable settlement in this particular case.

**Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital
Case Number 201506517 - Report issued in September 2016**

Mrs A complained about the care and treatment her late son, Mr Y, received from the Health Board between October 2012 and September 2013. In particular, she highlighted that Abertawe Bro Morgannwg University Health Board ("the Health Board") failed to manage her son's pain towards the end of his life. She also raised concerns about poor complaint handling.

The Ombudsman noted that the Health Board had identified as part of its investigation of Mrs A's complaint that there had been clinical failings with regards to the administration of supplementary pain relief to Mr Y. The Health Board apologised for the distress caused to Mrs A and her family. In addition, in recognition of delay in responding to Mrs A's complaint the Health Board offered Mrs A an ex-gratia payment of £250. Mrs A declined the payment.

As part of the settlement of Mrs A's complaint with the Ombudsman, the Health Board offered Mrs A the opportunity to meet with the Palliative Care Consultant and a representative from the Health Board's End of Life Care group to talk through Mrs A's concerns/experiences. The Health Board said it hoped to identify

ways in which Mrs A's experience might be used to influence ongoing education in the Health Board around the support of relatives and patients in the last hours/days of their life.

**Hywel Dda University Health Board – Clinical treatment in hospital
Case Number 201600043 - Report issued in September 2016**

Mr X complained that despite numerous attendances at Aberystwyth Eye Clinic, the ophthalmologists failed to properly diagnose his eye condition; a condition that was subsequently diagnosed and treated following a GP referral to an Ophthalmology Department at a different hospital for a second opinion.

Hywel Dda University Health Board ("the Health Board") said that, following a review of the complaint, it believed that Mr X's condition should have been identified earlier and to that extent, it acknowledged that the service he received was not all it would have wished.

The Health Board and the Ombudsman considered that the complaint could be resolved by way of an agreed settlement which included that the Health Board should:

- a) instruct and pay for an external clinical expert to establish the level of harm Mr X suffered as a result of the failure to diagnose
- b) determine an appropriate amount of financial redress for Mr X in light of the clinical expert's report
- c) offer to pay for Mr X to receive legal advice should he want it in relation to the reasonableness of any redress offer made by the Health Board (based on PTR redress arrangements).

Agriculture and Fisheries

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Welsh Government – Payment schemes

Case Number 201601567 – Report issued in September 2016

Mrs X complained about the lack of communication from Welsh Government in relation to her application and appeal for the Basic Payment Scheme Young Farmer Payment. She complained that some of her correspondence had not been answered at all, whilst some had contained misleading information. The Ombudsman found that this lack of contact could possibly be apparent in other claimants Basic Payment Scheme Young Farmer Payment applications.

A complaint made by Mrs X to Welsh Government regarding this lack of contact agreed that there had been errors in handling her correspondence however did not offer an apology or consideration of redress. The Ombudsman recommended the following early resolution to the complaint that the Welsh Government agreed to undertake within one month:

- a) Provide Mrs X with a written apology for its failure to communicate with her regarding her Basic Payment Scheme Young Farmer Payment application and appeal. This is to be issued within one month.
- b) Provide Mrs X with a redress payment of £400 to reflect the delays she experienced from Welsh Government in relation to the above. This redress payment is also to be issued within one month.
- c) Consideration is given to comparable actions in relation to any other individuals in similar circumstances to Mrs X. If any Stage 1 appeal letters are outstanding due to the communication with the European Commission then these are to be considered for immediate issue.

Complaints handling

UPHELD

Cwm Taf University Health Board - Health Case Number 201504399 – Report issued in September 2016

Mrs A complained that Cwm Taf University Health Board (“the Health Board”) failed to adequately deal with a complaint she made in October 2014 about the care and treatment she received following an operation. In particular, she was concerned that there were unacceptable delays in Cwm Taf University Health Board dealing with the matter, that the Health Board had still not determined whether there was a qualifying liability in her case and, despite agreeing in December 2015 to pay Mrs A £250 within six weeks in recognition of the delays, that the Health Board still had not done so at the time of the Ombudsman starting his investigation in March 2016.

The Ombudsman upheld the complaints. He found that there were unacceptable delays, errors in correspondence, and a failure to keep Mrs A up to date with what was happening. The Ombudsman recognised that the Health Board had already taken some steps to improve its handling of complaints. The Ombudsman recommended that the Health Board:

- a) provide a further apology
- b) pay £100 (on top of the £250 previously agreed) to Mrs A
- c) audit its outstanding redress cases which had exceeded the target for a response, and
- d) provide details of the actions being taken to ensure these are now resolved in a timely manner.

EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

City and County of Swansea - Planning and Building Control Case Number 201601588 – Report issued in July 2016

Mr W complained about Swansea Council’s (“the Council”) process of renumbering his property, which was being converted into three flats. Mr W said that the letters he received gave the impression that a voluntary registration fee to the Council was compulsory, and questioned the decision by the Council to allocate a numbering sequence to his properties that he did not choose. Mr W also said that when he made an official complaint, he experienced significant delays in communication, was not kept updated on the progress of his complaint and did not receive a clear explanation of the outcome of the Council’s investigation.

The Ombudsman found that the Council failed in the first instance to adequately address Mr W’s concerns around the numbering process and the decision it took to issue notice of the property numbering. The Council agreed to:

- a) apologise for the delays and the failure to address Mr W’s complaint
- b) offer a sum of £50 financial redress
- c) revisit the wording of relevant letters to ensure that the nature and benefits of the registration fee are clear, and

- d) complete these actions within four weeks of the Ombudsman's official notification

**Hywel Dda University Health Board – Health
Case Number 201601254 - Report issued in July 2016**

Ms X made a complaint to Hywel Dda University Health Board ("the Health Board") in November 2014 about the care and treatment she received whilst a patient at Prince Phillip Hospital ("the hospital"). After numerous attempts to contact the Health Board, the final response to her concerns remained outstanding.

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

- a) write to Ms X with an apology for the delay and an explanation
- b) provide Ms X with a payment of £500 for the delay
- c) provide its full response to the complaint by 30 August 2016.

**Merthyr Tydfil County Borough Council - Complaints Handling
Case Number 201601081 – Report issued in July 2016**

Ms X complained about several matters in relation to waste collection by Merthyr Tydfil County Borough Council ("the Council"). She has also made a complaint about staff conduct when she contacted the Council to discuss these issues.

No evidence of service failure has been found in relation to the waste collection issues however the Ombudsman recommended the following settlement, which the Council have agreed to undertake:

- a) send Ms X a full response to her complaint about staff conduct by 22 July 2016
- b) apologise to Ms X for the delay in sending a response to her.

**United Welsh Housing Association - Housing
Case Number 201602695 - Report issued in August 2016**

Mr X complained that about the length of time it took United Welsh Housing Association ("the Housing Association") to replace his front door. Mr X also complained about how the Association handled his complaint.

Following contact by the Ombudsman, the Association agreed to arrange a meeting with Mr X to discuss his ongoing concerns. This meeting should be arranged by 1 September 2016.

**Cardiff and Vale University LHB - Health
Case Number 201602749 - Report issued in August 2016**

Mr A complained about Cardiff and Vale University Health Board's ("the Health Board") ongoing delay of over 13 months in responding to his complaint.

Following contact by the Ombudsman, the Health Board agreed the following actions to settle Mr A's complaint:

- provide its response to Mr A's complaint by 12 September 2016
- provide a written apology to Mr A and his solicitor for the excessive delay
- pay Mr A £250 for the delay and any distress caused as a result.

Hywel Dda University Health Board - Health

Case Number 201602059 - Report issued in August 2016

Mrs T complained about the delay and communication difficulties experienced with Hywel Dda University Health Board ("the Health Board") in relation to its investigation of concerns raised about the treatment provided to her late husband. Mrs T's original complaint was submitted in November 2015.

Having considered the complaint the Ombudsman contacted the Health Board who agreed that there had been a delay in the provision of the final investigation report and that there had been some issues with communication. In recognition of this the Health Board agreed to:

- a) provide the final investigation report within one month
- b) arrange a meeting with Mrs T to discuss its findings
- c) provide a meaningful apology to Mrs T
- d) make a payment of £250 in recognition of time and trouble taken to pursue these concerns.

Newport City Council – Children's social services

Case Number 201601456 - Report issued in August 2016

Mr & Mrs D complained that Newport City Council ("the Council") had made errors in its calculation of Special Guardianship payments paid to them; failed to adequately explain how it concluded that they had been overpaid; and had failed to respond to their request for a meeting in the company of their accountant to discuss the payment calculations.

The Ombudsman could not change the basis upon which the payments were calculated, as they were based upon statute and an assessment of an individual's income. However, the Ombudsman found that there were two instances of maladministration by the Council. Contrary to Welsh Government Guidance, it had not re-assessed Mr & Mrs D's entitlement when they notified their change of circumstances but had left it to the annual review months later. At that point it became evident that Mr & Mrs D had been overpaid. Furthermore, when re-assessing, the Council failed to use the correct sum resulting in a further error leaving Mr & Mrs D having been overpaid by a significant sum (over £800), through no fault of their own.

The Ombudsman obtained the Council's agreement to implement the following as a means of resolving the complaint:

- a) an apology in writing within 20 days for the Council's failures in the re-assessment, and an assurance it would promptly undertake any necessary re-assessments in future
- b) written confirmation that it would not seek to recover the overpayment from Mr & Mrs D

- c) an agreement to hold a meeting with Mr & Mrs D and their accountant to fully explain how payments were calculated to ensure future clarity and understanding.

**Betsi Cadwaladr University Health Board – Health
Case Number 201603001 – Report issued in September 2016**

Miss A with the assistance of her CHC adviser complained about an unreasonable delay on the part of Betsi Cadwaladr University Health Board (“the Health Board”) in responding to concerns raised about the care and treatment provided to her late mother. Miss A complained initially in June 2014 and a response was received in August 2014. Further concerns were then raised in December 2015 a response is yet to be received.

Having considered the complaint the Ombudsman contacted the Health Board who agreed that there had been a period of long delay in the provision of the further complaint responses to Miss A. In recognition of this the Health Board agreed that as soon as possible and by 30 September 2016 it would:

- a) respond to Miss A’s further concerns
- b) provide a meaningful apology to Miss A recognising the delays experienced
- c) make a payment of £125 in recognition of time and trouble taken to pursue these concerns.

**Powys County Council - Community Facilities, Recreation and Leisure
Case Number 201601720 – Report issued in September 2016**

Mr K complained to Powys County Council (“the Council”) about its change of policy concerning waste and recycling collection which, he said, meant he would be greatly inconvenienced and would be difficult for him to keep to. He complained that the Council had failed to respond to his concerns or to his subsequent complaint about that failure. Shortly after making the complaint to the Ombudsman Mr K moved permanently from the Council’s area.

On assessing the documentation supplied, the Ombudsman considered that there was prima facie evidence of maladministration but, in light of Mr K having moved, he felt that the matter was capable of being resolved. The documents showed that the delay in Mr K’s case was as a result of the Council mixing up his complaint with a similar complaint from another resident in the locality. The Council agreed to implement the following (within one month) as a resolution of Mr K’s complaint:

- a) apologise to him in writing for the complaint handling failures
- b) offer him redress of £50 for his time and trouble in pursuing his grievances with both the Council and the Ombudsman’s office
- c) the Senior Corporate Complaints Officer would issue a reminder to all staff in the waste and recycling department about recognising a complaint and the Ombudsman’s guidance on this issue.

Hywel Dda University Health Board - Health

Case Number 201603155 – Report issued in September 2016

Mr X's complaint related to the treatment which Mrs Y received at Bronglais General Hospital. In particular, the alleged delayed diagnosis and treatment of infection within the knee following knee replacement surgery. Although Mr X put the concerns to Hywel Dda University Health Board ("the Health Board") in February 2016, the final response remained outstanding.

The Health Board were contacted and in settlement of the complaint agreed to provide Mr X with a final response to the complaint by 7 October 2016.

Clocaenog Community Council - Planning and Building Control

Case Number 201602536 – Report issued in September 2016

Ms X complained that Clocaenog Community Council ("the Community Council") declined to comment on issues of concern she raised with it. The Community Council responded to the complaint saying that the Members noted the contents of the letter and resolved not to make representations to it.

Ms X was advised that when a public body receives a formal complaint about its actions, it has a duty to respond to the concerns raised with it. After reviewing the complaint and response the Ombudsman contacted the Community Council and asked it to reconsider the complaint and provide a full and sufficient response. Ms X has since received a full written response.

Betsi Cadwaladr University Health Board - Health

Case Number 201602537 – Report issued in September 2016

Mr X complained he had not received a response to his concerns raised with Betsi Cadwaladr University Health Board ("the Health Board") on 28 February 2014. The Ombudsman contacted the Health Board and it has agreed to undertake the following in settlement of Mr X's complaint:

- a) provide a written apology for the continued delays
- b) offer monetary redress in recognition of the time and trouble in pursuing this complaint
- c) provide a full written response no later than 1 November 2016, failing which it has agreed to further extend limitation to 31 January 2017.

The Ombudsman believed that the action which the Health Board had said it would take was reasonable and would resolve this complaint. Accordingly, he considered the matter to be settled. Mr X was advised to come back to the Ombudsman should the action promised by the Health Board not materialise or was unsatisfactory.

Hywel Dda University Health Board - Health

Case Number 201601017 - Report issued in September 2016

Ms B complained about Hywel Dda University Health Board's ("the Health Board") failure to respond to her concerns in a timely manner. Ms B complained to the Health Board on 30 April 2015 but despite protracted communication via her legal representative, the Health Board failed to respond to her complaint until June 2016.

The Health Board acknowledged that it had failed to respond to Ms B in a timely manner and apologised for this. In recognition of its failings, the Health Board offered Ms B a payment of £500. In addition, the Health Board's Chief Executive offered his assurances that improved processes had been put in place to ensure better monitoring of complaints.

Education

NOT UPHELD

Cardiff Council - Exclusions

Case Number 201504956 - Report issued in August 2016

Mrs X complained that Cardiff Council ("the Council") failed to fully investigate her concerns about the circumstances leading to her son, Y's, withdrawal from a High School in its area.

The Ombudsman found that full consideration had been given to the review process, including the timescales for response. Furthermore, the findings had been outlined in the Council's correspondence to Mrs X. Therefore the Ombudsman did not uphold the complaint.

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Carmarthenshire County Council – School transport

Case Number 201602129 - Report issued in August 2016

In December 2015 Mrs Q met with Carmarthenshire County Council ("the Council") regarding the failed appeal in relation to her daughter's application for school transport. A review of the appeal was promised by the Council; however, Mrs Q approached the Ombudsman in July 2016 when she had not received the report.

On receipt and assessment of the complaint, the Ombudsman contacted the Council to discuss Mrs Q's concerns. Upon conclusion of those discussions, the Council agreed to take the following action to resolve the complaint:

- a) write a letter of apology to Mrs Q for the delay in issuing the review of the appeal
- b) make a payment of £50 to Mrs Q for the continued delay; and
- c) issue the review of the appeal within 20 working days.

Vale of Glamorgan Council – Special Educational Needs (SEN)

Case Number 201503572 – Report issued in September 2016

Mr X complained that Vale of Glamorgan Council ("the Council") in its role as the Local Education Authority ("LEA"), failed to provide his daughter, B, with the appropriate educational provision to meet her special educational needs ("SEN"); delayed in referring B to Speech and Language Therapy ("SALT"); and misinformed him about appealing to the Special Educational Needs Tribunal Wales ("SENTW").

The Ombudsman's investigation revealed Mr X was correctly informed of his right to appeal to SENTW, and there was no evidence that he had been misinformed by the LEA, as alleged. B now has a SEN Statement in place which reflects all the recommendations set out in B's SALT report.

Some concerns were identified in the timeliness of B's SALT referral and the Council's complaints handling. These were addressed by actions the Council had already taken including additional actions it agreed to take.

Mr X's complaint was discontinued on the basis of a voluntary settlement. The Council agreed to:

- a) provide Mr X with an apology and financial redress for the shortcomings identified in complaints handling, and
- b) that the LEA would provide B with additional hours of support for the academic year 2016/17 to assist the school to enhance B's current educational provision.

Environment and Environmental Health

UPHELD

Flintshire County Council - Other

Case Number 201500884 – Report issued in July 2016

Mr A complained about Flintshire County Council's ("the Council") failure to prosecute his neighbour for what he felt were listed building offences, which included the demolition of a wall. He was also dissatisfied with the Council's handling of his complaints.

The Ombudsman concluded that the decision about whether the wall formed part of the listed structure was a matter for the Council. He found no evidence that the Council's consideration and subsequent decision on the extent of the listed building curtilage was flawed. This aspect of Mr A's complaint was not upheld.

The Ombudsman felt that the Council could have provided Mr A with its definitive view about whether the development at the neighbour's property contravened listed building regulations much sooner than it did. He concluded that the delay had compounded the frustrations that Mr A had experienced. To that extent only he upheld Mr A's complaint. The Ombudsman recommended that the Council:

- a) apologise to Mr A for the shortcomings in its handling of his complaint, and
- b) pay him a sum of £250 for the time and trouble he had incurred in pursuing the complaint.

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Vale of Glamorgan Council - Refuse collection

Case Number 201601107 – Report issued in July 2016

Ms A complained to the Ombudsman because she was unhappy with the Vale of Glamorgan council's ("the Council") decision not to refund an administration fee of £15. Ms A booked a bulky waste collection through the Council's Contact Centre. Ms A said that when she called the Contact Centre the following day to cancel the collection she was informed the fee was non refundable. Ms A complained that she was not reminded the fee was non-refundable when booking the appointment.

The Ombudsman considered the complaint and after discussion with the Council they agreed to undertake the following action:

- a) produce a policy document which makes it clear that the administration fee of £15 for booking a bulky waste collection is non refundable on cancellation
- b) make changes to its website to clearly state that the £15 administration fee is non-refundable on cancellation of a collection
- c) refund the £15 payment as a gesture of goodwill. It must be pointed out that this was a onetime payment and would be refunded on this occasion only.

Carmarthenshire County Council - Drainage/Sewers/Culverts

Case Number 201601187 - Report issued in July 2016

Ms X's complaint related to concerns regarding the flow of human effluent passing the entrance to her property. Ms X raised further concerns regarding the failure of Carmarthenshire County Council ("the Council") to respond and deal with this complaint efficiently.

On contacting the Council it was has agreed that it would provide Ms X with a payment of £100 in recognition of the time and trouble taken for her to complain, and the avoidable distress this caused Ms X.

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

Case Number: 201601950 – Report issued in September 2016

Mrs X complained that Wrexham County Borough Council ("the Council") had failed to collect her large green compost and food waste bin on numerous occasions. This was despite Mrs X previously raising this issue with the Council.

On receipt of the complaint, the Council agreed to undertake the following in settlement of the complaint:

- a) arrange a face to face meeting between Mrs X and the relevant manager
- b) provide assurances that the matter will be looked at again, and;
- c) provide Mrs X with a payment of £50.

Housing

UPHELD

Bron Afon Community Housing Ltd – Neighbour disputes and anti-social behaviour Case Number 201503581 - Report issued in September 2016

Miss X (an owner-occupier) was concerned about the way Bron Afon Community Housing Ltd ("the Housing Association") dealt with her complaints of anti-social behaviour ("ASB") against her neighbour, a tenant of the Housing Association. In particular, she complained that BA had not effectively investigated her complaints of ASB and had not taken appropriate action in response to her complaints over a number of years. She also complained that the Housing Association failed to support her.

The Ombudsman found that, in the main, the Housing Association made reasonable efforts to resolve Miss X's complaints. He also found that when matters escalated, BA took action that was in accordance with relevant procedure. However, the Ombudsman did identify a number of shortcomings, namely, that the Housing Association failed to manage Miss X's expectations about what action it could take (which it acknowledged), was not rigorous enough in its record keeping (including failing to keep records of formal decisions), and failed to communicate effectively with Miss X about the way it was managing her complaints of ASB. The Ombudsman also found that, whilst the Housing Association took action as a result of Miss X's complaint to this office, (including meeting with her and putting an action plan in place to monitor the situation), there was nothing to preclude the Housing Association from taking this action sooner, which may have given Miss X assurance that the matter was being monitored and taken seriously.

The Ombudsman upheld Miss X's complaint to the extent of the shortcomings outlined above. He recommended that the Housing Association should:

- a) apologise to Miss X for the failings
- b) issue a reminder to staff about the importance of record keeping, and
- c) consider what lessons it could learn from the complaint and whether additional mechanisms needed to be put in place to address the identified failings.

EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

RCT Homes - Repairs and maintenance

Case Number 201600132 - Report issued in July 2016

Mr X complained that RCT Homes had failed to attend an agreed appointment and took too long to complete the repairs to the roof of his property. He also raised concerns that his complaint was not dealt with effectively.

The Ombudsman contacted RCT Homes and suggested that there was action it might take to resolve the matter. In settlement of the complaint, they agreed to write a letter of apology for the delays in completing the repairs and the failings in effectively dealing with the complaint. They also agreed to make Mr X payment of £250 to reflect the time and trouble taken by him in making his complaint, the distress caused to him through the delays in completing the repairs and for causing him to take a day's leave when the contractor failed to attend.

Ceredigion County Council - Repairs and maintenance

Case Number 201506924 - Report issued in July 2016

Miss A complained that Ceredigion County Council ("the Council") contractor caused damage to her property when it carried out improvement works, funded by a Disabled Facilities Grant.

The Council had agreed to undertake further work to repair the damage; however, it was waiting for confirmation from Miss A before proceeding.

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

Linc – Cymru Housing Association – Repairs and maintenance

Case Number 201602324 – Report issued in July 2016

Mr and Mrs A complained that scaffolding erected in January 2016 was still in situ and blocking natural light in the living room and bedroom. The scaffolding was originally set up so that Linc-Cymru Housing Association's contractors could repair the leaking chimney stack. Mr and Mrs A also complained about the length of time it was taking to carry out repairs both internally and externally.

Linc-Cymru Housing Association acknowledged the delays and took steps to ensure the situation did not happen again. It also agreed to the following actions:

- a) to renew the lead work and render to the shared chimney
- b) to complete the work and remove the scaffolding by 5 August
- c) to carry out necessary remedial work caused by roof leak
- d) to convey apologies for the delay and discuss a goodwill gesture payment of £100.

Cardiff Council - Housing - Repairs and maintenance

Case Number 201600784 - Report issued in July 2016

Mr S removed the kitchen floor at his mother's address following the belief that he had obtained Cardiff Council's ("the Council") permission to do so. Mr S complained that the Council disagreed that he had obtained permission and it was seeking to charge the cost of £635.44 for the repair to replace the flooring.

The Ombudsman found that there was a misunderstanding and/or breakdown in communication between Mr S, the Council and its contractors regarding the extent of works to be carried out. He found that Mr S was not given a definitive 'yes' or 'no' answer to his request to remove the floor, but Mr S was advised 'it's up to him' on the grounds of health and safety. Mr S therefore had a reasonable expectation that he had obtained the Council's permission to remove the floor and in the event that he sustained an injury, he accepted that the Council would not be held liable. The Ombudsman found no evidence to suggest that Mr S was advised that he would be charged for any costs incurred as a result of the Council carrying out repairs to any damage caused as a result of Mr S's actions. He concluded that Mr S had lost the opportunity to make an informed decision about whether or not he should remove the floor.

The Council agreed to carry out the following actions:

- a) not to impose the cost of £635.44 on Mr S
- b) remind staff of the importance of informing tenants that they may be charged for any damage caused from works undertaken by the tenant.

**Wrexham County Borough Council - Repairs and maintenance
Case Number 201601685 – Report issued in July 2016**

Mr X complained that:

- a) Wrexham Council ("the Council") agreed to repair works to his property in March 2015 and not October 2015 as stated in its final response to him
- b) there remained damage to his property from repair works
- c) damage had been done to his driveway and garden.

Mr X also complained that a surveyor had not yet been to his property, but, since first complaining to this office, this has now happened and Mr X agreed that the works completed inside his property were to his satisfaction.

The Council agreed to the Ombudsman's recommendations to complete the following actions within two months:

- a) provide an apology for the misunderstanding regarding what repair works were to be completed at the property
- b) repair holes to the outside walls of the property
- c) clean the driveway of any paint spillages/rubbish remaining from the completion of the repair works.

**Wrexham County Borough Council - Repairs and maintenance
Case Number 201601508 – Report issued in July 2016**

Mr X complained that Wrexham council ("the Council") failed to complete works to his home. Mr X provided correspondence that he had received from the Council confirming that an inspection was carried out on 5 January 2016.

The Ombudsman noted from the Council's policy that non-urgent repairs "will be completed within 120 calendar days from the defect report date". The Ombudsman therefore contacted the Council to request that it commit to finalising the repairs, pay the redecorating contribution money it had earlier offered and provide a written apology for the delay.

Following contact by the Ombudsman, the Council attended Mr X's home to assess the outstanding works. The Council wrote to Mr X the following day outlining the works that had been completed and confirming what had been agreed to finalise the outstanding works. It also provided its written apologies.

The Ombudsman considered that the action which the Council had taken and said it would take was reasonable and would resolve the complaint. Accordingly, the Ombudsman considered the matter to be settled. However, Mr X has been advised to come back to us if the action promised by the Council does not materialise or is unsatisfactory.

Derwen Cymru Housing Association - Tenancy rights and conditions/abandonment and evictions

Case Number 201601231 - Report issued in August 2016

Mrs X complained that her landlord, Derwen Cymru Housing Association ("the Housing Association") did not consult her prior to taking steps to de-pool service charges from the rent payable which it implemented earlier this year. She further complained that the grounds maintenance service charge for the estate was only being paid for by tenants and not the homeowners or leaseholders who also enjoyed the benefit of the grounds. Finally, she was concerned about the Housing Association's complaint policy as it refused to take her complaint to the Board members.

Whilst there were no failings found in relation to Mrs X's complaints about the lack of consultation prior to the de-pooling exercise, given the Housing Association had no option but to implement de-pooling, or the application of its complaints policy, the Ombudsman recommended the following settlement regarding the grounds maintenance service charge:

- a) recalculate the service charge for tenants on the estate so that the actual grounds maintenance payments reflect the removal of the homeowners and leaseholders portion of the costs by the end of September 2016
- b) refund the relevant portion of those costs to the residents who had already paid sums directly by the end of September 2016
- c) apply the same principle when calculating all other service charges for communal costs by the end of September 2016.

The Housing Association agreed to the above.

Trivallis Housing Association – Repairs and maintenance

Case Number 201602441 - Report issued in August 2016

Mr X complained that he had contacted the Housing Association in relation to a hole in his roof and remained unhappy that no action had been taken. During the recent bad weather, Mr X's roof leaked badly. This caused Mr X to slip on the water and injure his shoulder badly.

The Housing Association agreed to liaise with the contractors to request a further visit to investigate while the weather is bad.

Cardiff Council - Repairs and maintenance

Case Number 201602566 – Report issued in September 2016

Mr M complained that Cardiff Council ("the Council") failed to raise a repair order for his rented garage in a timely manner and that when he raised concerns the Council's response was unsatisfactory and the complaint investigation was neither appropriate nor independent.

The Ombudsman found that the repair request was delayed owing to an issue with the Council's computer

systems. The Council failed to identify this in its complaint investigation, and consequently overlooked an opportunity to achieve a satisfactory local resolution.

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

- a) apologise for shortcomings in complaint handling and investigation
- b) reimburse Mr M for the days he was unable to access his garage
- c) offer a payment of £100 for Mr M's time and trouble
- d) consider whether it required a policy regarding repairs of this nature.

City and County of Swansea - Repairs and maintenance

Case Number 201603281 – Report issued in September 2016

Mr X complained that ongoing repair work to his property had not been completed correctly and that there were remaining issues to be addressed. He also complained about the way in which Swansea Council ("the Council") handled his complaints.

The Council agreed the following actions in order to settle Mr X's complaint:

- a) complete the overdue work at Mr X's property by Friday 7 October 2016
- b) provide a written apology and explanation for the delays in completing the work by Friday 7 October 2016, and
- c) provide a £250 reduction in the land charge figure repayable by Mr X on future sale or transfer of title of the property to reflect the time and trouble in making his complaint to the Ombudsman.

Tai Ceredigion Cyf – Repairs and maintenance

Case Number 201506238 - Report issued in September 2016

Ms X complained to Tai Ceredigion Cyf ("the Housing Association"), about disrepair at her late mother's former home. She complained that a number of rooms in the house were not fit for habitation for a number of years.

The Ombudsman found, via an independent surveyor's report obtained by Ms X, that there were significant disrepair issues at the property. The Ombudsman also found that there were significant delays in responding to the concerns Ms X raised about them. The Housing Association accepted that there had been significant failings and its Chief Executive met with Ms X to discuss them and to offer his personal apologies. The Housing Association also apologised in writing, arranged a learning event for all staff involved in monitoring the condition of the property, agreed to carry out an audit into the condition all of its properties and offered redress of £3,350 in recognition of the distress caused and in reimbursement of the surveyor's fee.

The Ombudsman considered this to represent a fair settlement and discontinued his investigation.

Planning and Building Control

UPHELD

Powys County Council – Handling of planning application (other)

Case Number 201502704 - Report issued in August 2016

Mr & Mrs A complained about the delay in Powys County Council (“the Council”) dealing with a planning application that was submitted for two dwellings near their home. They said that in relation to these applications the Council failed to follow its planning protocol and did not follow up enforcement action when the developer did not comply with the planning permission. They were also dissatisfied with the Council’s handling of their complaint.

The Ombudsman’s investigation did not identify any failings by the Council in respect of the planning issues raised. This aspect of Mr & Mrs A’s complaint was not upheld.

However, the Ombudsman found there was a delay by the Council in responding to Mr & Mrs A’s complaint and upheld this aspect of their complaint. As the Council had previously apologised to Mr & Mrs A for the delay and offered a payment of £250 in recognition of this, the Ombudsman made no recommendations.

NOT UPHELD

Conwy County Borough Council – Handling of planning application

Case Number 201501085 - Report issued in July 2016

Mr and Mrs X, Mr and Mrs Y and Mrs Z complained about how Conwy County Borough Council (“the Council”) granted planning permission for the construction of a balcony on the side of a house on the estate where they lived. They were concerned that the development would result, among other things, in an invasion of privacy, overlooking, overdevelopment and loss of light. They considered that the application process was unfairly prejudiced in favour of approval and they believed that it had not been handled diligently.

The Ombudsman found that, on the whole, the assessment of the application had been properly undertaken with the relevant factors considered. There had been a failure to specifically refer in that report to the supplementary planning guidance which was directly relevant to the application, but that did not amount to maladministration as the issues covered by the guidance appeared to have been properly considered as part of the decision-making process. The Ombudsman therefore did not uphold the complaint.

EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

Neath Port Talbot County Borough Council – Handling of planning application (other)

Case Number 201601446 – Report issued in July 2016

Mr T complained that Neath-Port Talbot council (“the Council”) had failed to respond to a number of his recent complaints. Mr T said that the Council has previously decided unnecessarily to treat him as an

unreasonable and persistent complainant. In consequence of this he experienced difficulty raising concerns with the Council.

Enquiries identified that although the decision to deal with Mr T's complaints in this manner had been reasonable, this decision had not been formally reviewed for some time and there had been some inconsistency in its application. The Council subsequently took steps to respond at stage 2 to all outstanding complaints.

The Ombudsman asked the Council to:

- (a) review Mr T's status under the Corporate Comments, Compliments and Complaints Policy
- (b) write to Mr P to advise him of the position and to provide clear guidance as to the nature of new complaints that can be made, to whom such complaints should be directed and when this will be reviewed.

The Council agreed to implement these requests within 28 days.

Powys County Council - Unauthorised development Case Number 201601744 – Report issued in July 2016

Mr G complained that when he sent a query to Powys County Council ("the Council") regarding a development near his property which had not received planning permission, he did not receive a response and was not updated on the Council's decision or actions regarding the matter. Mr G said that his formal complaint about the lack of response from the service area in the Council also went unanswered.

The Ombudsman found that the Council failed to seek clarification on the substance of his formal complaint and therefore did not acknowledge or respond to his complaint appropriately.

The Council agreed that within seven working days it would undertake the following actions in settlement of the complaint:

- a) apologise for the shortcomings in handling your complaint
- b) offer a sum of £75 financial redress for your time and trouble.

Isle of Anglesey County Council – Other planning matters Case Number 201601736 - Report issued in August 2016

In December 2015 Mr M contacted Isle of Anglesey County Council ("the Council") with concerns about a new school being built close to his property. The Council responded that the application had been approved by the Planning Committee and building works would continue. Mr M remained unhappy and approached the Ombudsman in June 2016.

On receipt and assessment of the complaint, the Ombudsman contacted the Council to discuss Mr M's concerns. Whilst the Ombudsman was satisfied that the Council had considered the application in accordance with relevant policies and guidelines, the Council agreed to take the following action to resolve the complaint:

a) The Council's Enforcement Team would visit the site of the new school and measure the distances between the new building and Mr M's boundary wall and the height of the building to ensure that they are in accordance with the approved plans. It would then notify Mr M of the outcome.

Flintshire County Council - Other planning matters

Case Number 201602753 – Report issued in September 2016

Mr A raised a number of concerns in his letter to Flintshire County Council ("the Council") dated 7 January 2016 regarding the proposed Gypsy Traveller Site.

Mr A complained that the Council had failed to provide a response to his letter. Also, the Council had failed to adequately respond to criticism regarding the lack of enforcement or address a challenge to the professionalism and integrity of an officer.

Following consideration of the complaint, the Ombudsman contacted the Council to discuss Mr A's concerns. The Council agreed to undertake the following in settlement of the complaint:

- a) to provide a response to Mr A's letter by 20 October 2016
- b) to provide an explanation regarding why a response was not provided sooner and (if appropriate) apologise for any delay.

Social services - Adult

UPHELD

Conwy County Borough Council – Services for older people Case Number 201501150 - Report issued in August 2016

Miss A complained that Conwy County Borough Council (“the Council”) did not respond appropriately to her concerns about the domiciliary care given to her mother, Mrs B, by three different private agencies. She also complained that the Council did not, in spite of her requests, give her support as Mrs B’s carer. She indicated that she was dissatisfied with the Council’s response to her complaints about these issues.

The Ombudsman found that the Council had not demonstrated that it had responded to all of Miss A’s concerns about Mrs B’s domiciliary care properly. He established that it had not completed a carer’s assessment, in respect of Miss A, and considered that it should have done so. He also determined that it had failed to take the action that it had agreed to take, in relation to these matters, in response to the formal investigation completed by an Independent Investigating Officer. He partly upheld the domiciliary care and support aspects of Miss A’s complaint as a result.

He recommended that the Council should:

- a) write to Mrs B and Miss A to apologise for the failings identified and to give them more information about how Miss A’s domiciliary care concerns were dealt with
- b) provide training for social work staff about how to address such concerns, and to share the training material used with Mrs B and Miss A.

The Council agreed to implement these recommendations.

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Betsi Cadwaladr University Health Board and Wrexham County Borough Council - Services for vulnerable adults

Case Numbers 201602261 / 201601162 - Report issued in August 2016

An advocate complained on behalf of Mrs A that Betsi Cadwaladr University Health Board (“the Health Board”) and Wrexham County Borough Council (“the Council”) had not followed Protection of Vulnerable Adult policies regarding the investigation of concerns in that they had refused to investigate her complaint.

Mrs A had submitted a composite complaint about both bodies, it had been very detailed, and she had been asked to provide a list of specific complaints for them to be considered; when she had not done so, the bodies had said they were unable to investigate the complaint. When contacted by the Ombudsman, the Council and the Health Board both agreed to deal with Mrs A’s complaints, once she provided a more focussed list of her concerns.

**Caerphilly County Borough Council - Other
Case Number 201602346 - Report issued in August 2016**

Mr A and Ms X complained that Caerphilly County Borough Council ("the Council") had not followed its guidance document 'Paying for Residential and Nursing Care' (the "guidance") in relation to charges for respite care provided to Ms X. They specifically complained that a financial assessment was not carried out correctly and that they were not given a choice of how to pay for the service.

Whilst no failings were found in relation to how the assessment was conducted by the Council or in the collection of payment for the service, the Ombudsman found that the current guidance was misleading for respite clients.

Therefore, the Council agreed to the following within one month of receipt of the decision letter:

- a) issue a written apology to Mr A and Ms X for the misunderstanding concerning the guidance.

In addition, to amend the guidance as below within two months of receipt of the decision letter:

- a) a paragraph be added explaining that if there has previously been a financial assessment for respite care then it is unlikely that an appointment or visit from the Income Maximisation Team is required
- b) A paragraph be added explaining that for short term care / respite clients a one off invoice is generated and these clients do not have the option to pay via direct debit.

**Flintshire County Council – Services for people with a disability including DFGs
Case Number 201504265 - Report issued in September 2016**

Ms A's sister Ms B was awarded direct payments by Flintshire County Council ("the Council") on 19 February 2015. Ms A complained that the Council had failed to make backdated direct payments for the care she provided.

The Ombudsman's investigation found evidence of maladministration by the Council. The Council agreed to settle Ms A's complaint on the following terms:

- a) the Chief Executive would apologise in writing for the administrative shortcomings in dealing with Ms A's request for backdated payments
- b) in recognition of the distress and inconvenience caused to Ms A by the failings it would make a payment to her of £250
- c) the Council would make the backdated direct payments owed to Ms A
- d) the Council would review Ms A's case to consider what lessons could be learnt to prevent a

recurrence and take steps to implement any measures/actions identified as being required.

Social services - Children

UPHELD

Cardiff Council - Other

Case Number 201501494 - Report issued in July 2016

Mrs D was a registered foster carer with a private agency. She complained about the actions of Cardiff Council ("the Council") and the way it handled matters following the conclusion of an investigation into her complaint about how historic allegations against her were dealt with. She complained that the Council failed to comply with its own complaints procedure and timescales in responding to the investigation report on her complaint. She also complained that it failed to implement the recommendation made by the investigation that a strategy meeting should be reconvened so that Mrs D could be provided with an opportunity to provide her account.

The Ombudsman found that the Council's response to the investigation fell short of the requirements of relevant guidance. He upheld the first complaint. He partially upheld the second complaint. He found that, whilst the recommendation was not carried out as outlined by the Council in its response, a reconvened strategy meeting had taken place which considered information previously provided by Mrs D to the private foster agency in response to the allegations.

The Ombudsman recommended that the Council:

- a) apologise to Mrs D
- b) review its complaints policy to ensure compliance with regulations, and
- c) invite to Mrs D to provide her comments on the allegations which if different or new to those already provided, should lead to a reconvened strategy meeting.

Flintshire County Council – Social care assessment

Case Number 201504670 - Report issued in September 2016

Miss A complained about the failure/refusal of Flintshire County Council's ("the Council") social services department to provide services to meet her son's, B's, needs. She was unhappy that the Council had decided B did not qualify for services from the Children's Integrated Disability Service ("CIDS") and that the Council had failed to prepare for the family's move to the area.

The Ombudsman found that B did not meet the criteria for services from the CIDS team. However, there were unacceptable delays in transferring B to the Child in Need team, in carrying out assessments of his needs and in providing services to meet them. The Ombudsman was also critical of the way in which the Council dealt with Miss A's complaint. He upheld the complaint, and made recommendations that the Council:

- a) apologise to Miss A
- b) provide the relevant services for B if it was not already doing so, and
- c) provide refresher training for relevant members of staff.

The Council agreed to implement the recommendations.

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Pembrokeshire County Council - Other Case Number 201602050 - Report issued in August 2016

Mr & Mrs T complained that Pembrokeshire County Council ("the Council") failed to comply with recommendations arising from the independent investigation into complaints made by them. One issue of particular concern was the Council's commitment to open communication with them.

Whilst the Ombudsman was satisfied that Mr & Mrs T's concerns (which were largely upheld) were appropriately addressed in the independent investigation completed and that the recommendations approved by the Council were reasonable it was felt that there was an absence of a defined action plan demonstrating commitment to them.

Consequently the Council agreed to create an action plan clearly defining what actions will be taken, by whom and a date for review/completion within one month.

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

Case Number 201600312 - Report issued in August 2016

Mr & Mrs X complained about the way in which Powys County Council ("the Council") dealt with their son's needs during summer 2014 and were concerned about shortcomings in the Council's complaint response.

The Ombudsman settled this complaint on the basis of the action that the Council took to resolve the matter.

The Council:

- apologised to Mr & Mrs X and met with them to discuss their concerns
- provided evidence of learning and improvement as a result of the complaint
- wrote to Mr & Mrs X about the actions being taken.

The Council also agreed to:

- provide financial redress of £1,000 to take account of the distress caused and the time and trouble incurred in pursuing the complaint
- provide evidence of change in process to the Ombudsman and Mr & Mrs X
- offer a further meeting with the family if requested.

Cardiff Council – Other Case Number 201602974 – Report issued in September 2016

Mr C complained that Cardiff Council's ("the Council") Children's Services failed to accept part of an independent investigation finding that was upheld. The complaint related to an incident involving his son and his ex wife's delay in advising him of potential concerns surrounding her new partner. Mr C was concerned that the service had allowed too much time to elapse without intervening and advising him itself. Following consideration of the complaint, the Ombudsman agreed with the Council that it would write to the complainant providing reassurance that Children's Services would:

- a) feed the suggestion regarding setting a reasonable time period (to be agreed) to expect an individual to advise another individual, with parental responsibility of a child, of a situation that they should

be aware into the consultation of The All Wales Child Protection Procedures, which were about to be redrafted in line with the newly implemented Social Services and Wellbeing (Wales) Act 2014.

b) in future cases where this issue arises, Children's Services would ensure that individuals with parental responsibility are advised promptly, this would be closely monitored on a case by case basis.

The Council wrote to Mr C on 13 September 2016 providing the above assurances.

Various - other

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Newport City Homes - Other miscellaneous Case Number 201601774 – Report issued in July 2016

Mr F complained that Newport City Homes (“the Housing Association”) had failed to take his complaint seriously or investigate it thoroughly. Mr F also complained that the Housing Association failed to keep you informed throughout the complaint process or respond to requests for information.

The Ombudsman found that the Housing Association failed to escalate Mr F’s complaint, manage his expectations or respond to his concerns appropriately. The Ombudsman recommended that the Council:

- a) provide a fulsome apology for the shortcomings in the complaint
- b) address the ongoing concerns that the complaint had not been taken seriously.

Aberdyfi Community Council - Poor/No communication or failure to provide information Case Number 201600885 - Report issued in July 2016

Mr X complained about the failure of the Council to deal with correspondence in Welsh and, subsequently, for the Council’s failure to respond to any emails in Welsh from him (including a complaint made in March 2016 regarding the non-response). In ignoring the emails, in the opinion of Mr. X, the Council prevented a discussion on a topic which he believed to be important.

Having considered the complaint, the Council was required to undertake the following in order to settle the matter:

- a) apologise to Mr X for failing to respond to his correspondence and for failing to respond to his complaint
- b) undertake to respond to Mr X’s complaint
- c) undertake to adopt an appropriate written complaint policy
- d) consider how best to deal, in future, with correspondence received by the Council (either by email or by post) in Welsh.

The Council agreed to undertake these actions.

Abertawe Bro Morgannwg University Health Board - Other Case Number 201602350 - Report issued in August 2016

Mr & Mrs H complained that hospital staff referred them to Social Services referencing a concern around the handling of their newborn baby. However, staff made the referral without discussing their concerns with them or informing them of the referral before it was made.

The Ombudsman found that in its complaint response Abertawe Bro Morgannwg University Health Board (“the Health Board”) did not address Mr & Mrs H’s concerns adequately and failed to explain the circumstances around the referral or the evidence on which it was based

The Health Board agreed to undertake the following actions to resolve the complaint:

- d) apologise for the failure to address these issues within the complaint responses
- e) provide a full explanation and response to Mr & Mrs H's outstanding concern
- f) complete these actions no later than 30 September 2016.

Hywel Dda University Health Board - Poor/no communication or failure to provide information

Case Number 201601799 - Report issued in August 2016

Mrs X complained that after making a complaint to Hywel Dda University Health Board ("the Health Board") in December 2015 relating to treatment her late mother received, she was yet to receive a final response.

The Ombudsman contacted the Health Board and it agreed to undertake the following in settlement of the complaint:

- a) provide Mrs X with an update on her complaint
- b) provide Mrs X with a full response as soon as possible
- c) arrange a meeting between Mrs X and the Health Board (on date agreed by both).

Gwynedd Council - Miscellaneous

Case Number 201601452 - Report issued in September 2016

Mr A complained to the Ombudsman that his bins were not being returned after collection (in line with the back door collection arrangement in place) and that bins were being left after collection on top of the ramp near his disabled parking bay causing obstruction to his access.

Whilst Gwynedd Council ("the Council") had taken action to monitor the situation, the Ombudsman found that the action had not been fully carried out in accordance with what it told Mr A. The Ombudsman considered that there was further action the Council could take to address the complaint.

The Council agreed to:

- a) provide a further apology and offer of meeting
- b) pay £100 for the time and trouble in having to pursue the complaint
- c) provide a point of contact for Mr A within the waste services team to report problems (for the next three months)
- d) discuss with relevant crew
- e) continue to complete monitoring forms and take photographs after each collection to ensure the agreed action is being carried out
- f) carry out a review of arrangements on a monthly basis for the next three months.

**Rhondda Cynon Taf County Borough Council – Antisocial behaviour (not housing)
Case Number 201602764 - Report issued in September 2016**

Two elements of Ms T's complaint could not be considered as they were out of jurisdiction. A further element was out of time and another was considered to be resolved by actions that Rhondda Cynon Taf County Borough Council ("the Council") had already taken.

Ms T also complained that the Council failed to take action in relation to two Anti-Social Behaviour ("ASB") referrals received from South Wales Police ("the Police") and that it did not inform her of its decision not to take action. The Ombudsman found that the Council's reasons for not taking action were reasonable. However, it should have made Ms T aware of its decision. It was also found that comprehensive information about its procedure for dealing with ASB was not readily available to Ms T.

The Council agreed to settle this complaint by:

- a) providing Ms T with a written apology for the failings identified, and
- b) amending the ASB section of its website.

**Rhondda Cynon Taf County Borough Council – Miscellaneous
Case Number 201603029 – Report issued in September 2016**

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

The Ombudsman found that although the relevant documentation to Mr A's Compensation Order was completed by the department, instructions to make an application were not communicated to the legal representative resulting in a failure to submit his claim for compensation and ultimately Mr A was left with no other choice but to undertake Civil Court proceedings himself.

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

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

**Wrexham County Borough Council – Miscellaneous
Case Number 201602801- Report issued in September 2016**

Mr B complained that Wrexham County Borough Council ("the Council") had failed to repair a grass verge that was disturbed during road works carried out near his business premises. He also complained that the council's sub contractors had left rubbish in the car park of the premises which he had to clear away. He further complained that the sub contractors had failed to clear away works materials from a storage area that had been agreed between the two at the side of the car park.

It was apparent that the storage area had been a verbal agreement between the complainant and the sub contractor. The Council agreed to:

- a) write a letter of apology to Mr B and offer him an ex gratia payment of £100 in recognition of the time and trouble taken to make the complaint
- b) to rake and apply grass seed to the area of the verge disturbed during the works.
- c) to inform the sub contractor of Mr B's complaint and request for remedial work to be carried out to rectify the land used by it for storage.

More information

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

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