The Ombudsman's Casebook

Issue 5 July 2011

Inside this issue

A word from the Ombudsman 1

Lessons Learnt

Health - Follow-up care 3

Health - Nursing and Midwifery Care 4

General - Complaint Management 5

Case Summaries

Health 6

Planning and Building Control 19

Environment and Environmental Health 20

Housing 21

Adult Social Services 22

Children's Social Services 23

More Information 25

A word from the Ombudsman

Once more, health cases dominate this quarter's casebook. My office's annual report was published since the last Casebook and can be found here. This again reflects the increase in the numbers of health cases being considered by my office while complaints in other areas of the public service are broadly static. The health cases reported here are the outcomes of complaints made before the new health redress system became operational, and we will be watching with interest to see whether there is a further increase in complaints now that all independent consideration of health complaints has been consolidated in my office.

Two particular issues are worthy of consideration. The lessons learned section which follows particularly highlights the need to have effective systems in place for following up patients, especially where they are being treated for illnesses such as cancer where close monitoring is key to effective treatment. I would also like to re-emphasise a message which emerged from a previous Casebook, that is the importance of prompt referral of potential cancer patients by GPs. My office has unfortunately seen yet another case where a GP has not followed the two week cancer referral rule. In some instances, such cases have led to tragic consequences for the patients and their families.

(Continued overleaf)

Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

Finally, on the housing front, I was pleased to see that new draft guidance on housing allocations and homelessness has been issued by the Welsh Government. The case featured in this Casebook from Anglesey is a further example of the all too common failure to recognise when housing applications should be treated as homelessness applications and dealt with accordingly. It also reinforces the importance of having properly documented processes and procedures and ensuring that staff are appropriately trained to operate them effectively.

Peter Tyndall
Ombudsman

Lessons Learnt

Health

Follow-up care

During the last quarter, a number of cases have demonstrated the importance of ensuring that patients experience the highest possible level of follow-up care. Foremost amongst these cases is 201000665, in relation to which the Public Services Ombudsman for Wales issued a Public Interest Report.

In this case, the individual complained about the follow-up care he received after a diagnosis of prostate cancer. Although his treatment plan ought to have included 3-monthly check up appointments and a repeat biopsy after 12 months, the complainant did not receive a follow-up appointment until one year later, at which stage his cancer had advanced.

The investigation identified serious failings, including the existence of an 11-month backlog with no effective or urgent action taken to address the backlog. The investigation concluded that such fundamental failings called into question the governance of the relevant Health Board, and potentially placed patients at risk. Other failings identified by the investigation included a failure to adhere to NICE clinical guidance, a 'lesson' which was previously highlighted in Issue 3 of The Ombudsman's Casebook.

A further report (201000105) issued during this past quarter has also highlighted an example of unacceptable delay in the referral of a cancer patient. In this case, given the condition and the medical history of the patient in question, the investigation concluded that a six-week wait to see a Consultant following an urgent referral was not acceptable.

The full text of the Public Interest Report identified above can be found here. All health bodies are urged to read the entire report to ensure that such a situation does not arise again.

Key Questions:

Do we have any cases which require review in light of the above identified reports?

Do we have an appointment backlog?

Do we have any measures in place to tackle such a backlog?

Are our 'urgent referrals' carried out within acceptable/stipulated timescales?

Do we consider our standard of follow-up care to be acceptable?

Health

Nursing and Midwifery Care

In addition to the above examples relating to follow-up care, a number of reports issued during the last quarter have addressed the issue of care on the part of Nurses and Midwives.

In one case (201001484), an investigation found that the examples of poor Nursing care included inadequate management of a patient's fluid intake, and an inadequate standard of psychological monitoring. In a further case (201001059), an investigation concluded that a delay in providing a patient with an epidural meant that the patient had not received the level of midwifery care that she had the right to expect during the final hours of her labour.

It should be noted that 201001484 contained examples of a good nursing too. It is also worth highlighting the findings in relation to one further report issued during the last quarter (201001685). This case related to circumstances in which a complainant was asked to leave the premises of A & E due to their behaviour. The report considered whether staff acted with due regard for patient care, and found that there was no evidence that staff had acted unreasonably or outside the Health Board's policy.

When considering the standard of care offered to patients, the above cases illustrate that it is always necessary to consider the circumstances of each case. However, health bodies should always try to ensure that the highest possible standard of care is provided to their patients without exception, and that lessons are learnt from the good examples, as well as the poor examples of care.

Key Questions:

Have the above cases identified any concerns with the provision of Nursing or Midwifery care in our Health Board?

Are there any aspects of these care provisions which require or are due for review?

Do we keep adequate records in the event that we need to demonstrate an appropriate level of care?

General

Complaint Management

A number of reports issued during the past quarter have raised concern over the quality of complaint management by public bodies. This issue relates to the way in which public bodies have handled a complaint once it has been received. There have been recent examples where poor complaint management has resulted in a missed opportunity to resolve a complaint at an earlier stage, and without the need to involve the Public Services Ombudsman for Wales.

In one case (201001354), an investigation found that the successive responses from the body in question had failed to fully address concerns raised by the complainant. One response was considered to have been 'inappropriately brief'. In a further case (201000180), a health body's responses to a complainant were delayed and could have been more comprehensive. In a further case (201000325), a health body became muddled between responding to a complaint and dealing with the complainant's ongoing clinical care.

It is also important to consider who should handle either a complaint, or a subsequent review, after it has been received. In one case (200902417), a 'Stage 2 investigation' under the Council's Social Services complaints procedure was not completed within the required timeframe. Furthermore, when a second investigation was required, it was completed by the same investigator who carried out the first investigation. The report issued by the Public Services Ombudsman for Wales noted that it would have been better practice to appoint a different investigator.

The handling of complaints is often an integral part of a public body's service. It is also a way of reviewing actions and learning lessons. It is sometimes the case that investigations by this office will find greater fault with a public body's complaint handling, than the matter to which the initial complaint related. All public bodies are encouraged to ensure the highest possible standard of complaint management.

Key Questions:

Have we clearly identified the grounds of the complaint?

Have we addressed these grounds in our response?

Have we appointed an appropriate person to consider the complaint?

Is there an opportunity to resolve the complaint informally?

Have we undertaken a review in line with our procedures/guidance?

Case Summaries

Health Summaries

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

June 2011 – Appointments/admissions/discharge and transfer procedures – Hywel Dda Health Board

Mr C complained about his follow-up care from the Health Board after he had been diagnosed with cancer of the prostate. His active monitoring treatment plan ought to have involved 3 monthly check-up appointments from November 2008, with a repeat biopsy at 12 months. He said that he received no follow-up appointment until over a year later (when he enquired about the biopsy appointment in December 2009). When seen, his cancer had advanced. Mr C complained that a timely appointment would have meant the cancer's advancement being noticed earlier and an active treatment regime would have begun sooner. He was dissatisfied with the Health Board's response to his complaint feeling no adequate explanation had been given about the lack of follow-up care.

The investigation uncovered serious failures, including that the Health Board's Urology service at the relevant time had an appointment backlog of over 11 months; no effective or urgent action was taken to address the increasing backlog within that time; there were no written procedures for appointment making which was a function of the medical records department; ineffective liaison between the medical records department and clinical staff with no system of prioritising those patients in need of urgent follow-up appointments (such as Mr C who had a cancer diagnosis requiring close monitoring); and a consequential breach of NICE clinical guidance.

All shortcomings had severe consequences for Mr C. The Ombudsman was very critical of these fundamental failings which he felt called into question the Health Board's governance and potentially placed more patients at risk. In addition to making the circumstances known to Health Inspectorate Wales to monitor the Health Board's future appointment arrangements, the Ombudsman made a number of recommendations, including: an apology and redress of £3000 to Mr C for the failures and distress caused to him; a review of its appointments system across all specialties; an action plan to address the issue of timely follow-up appointments; and, accompanying written procedures regarding appointment booking. The Health Board agreed to implement all the recommendations.
Case reference 201000665

Upheld

June 2011 – Clinical treatment outside hospital – Cardiff and Vale University Health Board and GP in Health Board area
Miss A, aged 40 and a smoker, has adult onset diabetes. On 5 August 2009, she went to the former Trust's Accident and Emergency Department ("the A&E"), accompanied by her parents, complaining of pain in her left leg. She was examined by a Specialist Registrar who concluded that Miss A had vitamin B deficiency. Miss A was advised to see her GP the following day.

Miss A saw a GP at the Practice on 6 August and he prescribed her a painkiller for pain management and arranged for Miss A to have blood tests. Miss A telephoned the GP on 7 August and told him that her leg was "turning a funny colour" and that she was still in pain. Miss A said that the GP told her to continue with the painkiller and exercise her leg. Miss A said that she suffers from an arterial disease and the restricted blood supply causes an ischaemic leg (where the blood supply is compromised and in severe cases, without treatment, can lead to the loss of the limb). Miss A complained that she had to undergo an amputation of her leg above the knee as a result of poor care provided to her by both the Hospital and the GP.

The Ombudsman's investigation concluded that Miss A's condition and her symptoms were not fully explored on 5 August by the Specialist Registrar in the A&E and her complaint was upheld. The Health Board was asked to apologise for this failing.

In relation to the complaint against the GP, the Ombudsman concluded that his failure to record a telephone consultation with Miss A on 7 August was a breach of the standard of recording expected by the professional body that regulates doctors. He was also critical that the GP had failed to examine Miss A, or, at the very least, refer her to an A&E department given the symptoms that Miss A described to him.

The Ombudsman concluded that the failure to respond to Miss A's descriptions of her symptoms meant that the GP was unable to make an informed decision on the management of her care. Miss A's complaint was upheld and the Ombudsman recommended that the GP pay Miss A the sum of £1500 for the distress and the uncertainty of not knowing whether a prompt referral may have made a difference to her prognosis.
Case reference 201000275 & 201000361

June 2011 – Clinical treatment in hospital – Cardiff and Vale University Local Health Board
The complaint was made by Mr A's family about the care and treatment that the late Mr A received following his admission on two occasions to University Hospital of Wales.
During his first admission Mr A was prescribed Metolazone as a diuretic agent. Mr A was discharged home from hospital on the day he started taking the medication and, due to an error, he was not monitored as planned. The Ombudsman found that the prescription and administration of Metolazone was not properly supervised and monitored and he upheld the family's complaint.

Mr A's family also complained that Mr A's Warfarin medication had been ceased on his second admission and he had not been tested for Aspirin resistance. The Ombudsman did not uphold this element as it was not unreasonable for this action to have occurred in Mr A's circumstances. The investigation identified that there was a joint cardiology/nephrology strategy in place in respect of Mr A, and the Ombudsman also did not uphold the complaint that Mr A received a lack of cardiac monitoring following his second discharge from hospital.

Mr A's family also complained about the complaint handling by the Health Board. The Ombudsman upheld the complaint that there was a significant delay in responding to the complaint and found that the answers the Health Board provided to Mr A and his family could have been more accurate and complete. Mr A's family also complained about being told to take the complaint elsewhere. The Ombudsman considered that, in addition to recommending referral on, there were still some points of clarity and a confirmation of apology which could have been provided by the Health Board. To that extent, the Ombudsman upheld the complaint. Finally, the Ombudsman upheld the complaint that the Health Board failed to respond to the request for information on what had been done to prevent a reoccurrence of the error in medication monitoring.

The Ombudsman recommended that the Health Board apologises to Mr A's family in relation to the management of Metolazone, and provide a redress payment of £500 for the additional distress caused. He recommended that the Health Board ensure it has procedures in place for the proper monitoring of such drugs. He also recommended that the Health Board confirms that it has processes in place to ensure complaints are dealt with in a satisfactory manner and recommended a redress payment of £250 be paid to Mr A's family in recognition of the time and trouble associated with pursuing the complaints.
Case reference 201000407

June 2011 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board (formerly North Wales NHS Trust)
Ms F complained about the care provided for her late father, Mr D, by the Trust, when he was in hospital. She expressed concern about its management of his falls, his nutritional care, his fluid intake, his transfer to the Rehabilitation Unit and his pain relief. She suggested that its prescription of Haloperidol and Movicol, for him, was inappropriate. She complained that it did not try to replace Mr D's hearing aids and glasses.

The Ombudsman fully upheld those elements of Ms F's complaint which concerned Mr D's falls, his nutritional care and his Haloperidol prescription. He partly upheld the transfer aspect of it. He recommended that the Health Board should apologise to Ms F and Mrs D for the failings identified. He asked it to provide training on the Trust's Incident and Hazard Reporting Policy for staff members. He recommended that it should review the processes used by members of the Multi-Disciplinary Team for exchanging information. He asked it to remind staff members of the need for accurate record keeping. He recommended that it should review its Guidelines for the Inpatient Management of Delirious Elderly Patients and its delirium management training with reference to guidance issued by the National Institute for Clinical Excellence. He asked it to consider whether it is necessary for it to have a policy on the use of laxatives. He recommended that it should devise and implement a laxative policy if it concludes that it is necessary for it to have one.

The Health Board agreed to comply with all of the recommendations. The Ombudsman did not uphold those parts of Ms F's complaint which concerned Mr D's Movicol prescription, his fluid intake and his pain relief. He did not make a finding in relation to the hearing aids and glasses aspect of Ms F's complaint.
Case reference 201002402

June 2011 – Appointments/admissions/discharge and transfer procedures – Welsh Ambulance Services NHS Trust
Mr D complained about the service he received following an emergency '999' call. Specifically, he complained about the attitude of the attending paramedic, that there was a lack of recognition of his symptoms as a stroke and that he did not receive appropriate treatment as a stroke patient. He was concerned that his care had been compromised during the ambulance journey and on arrival at the local A&E department.

The Ombudsman was not able to reach a definite conclusion as to Mr D's complaints about the paramedic's attitude, but found that the paperwork indicated that the paramedic did not appear to have recognised Mr D's symptoms as a stroke. He was also critical of the Ambulance Trust's investigation into Mr D's complaint. He therefore upheld these aspects of the complaint. However, he concluded that Mr D's care had not been compromised as there is very limited care that can be offered to stroke patients before they reach hospital and Mr D was transported to hospital in a timely fashion. The Ombudsman recommended that the Trust should apologise to Mr D for the shortcomings identified and also review its investigation procedure and patient documentation.
Case reference 201001324

June 2011 – Clinical treatment outside hospital – GP Practice in Aneurin Bevan Health Board area
Mr H complained about a prescription error that occurred in 2004 while he was under the care and treatment of the Surgery. Mr H was provided with a repeat prescription for a steroid dexamethasone over a period of five months and believed that this medication error had caused his past and present health problems. In particular, he believed that this error was responsible for his recent blood hormone abnormalities. He complained about the advice provided by his GP once they became aware that he had been taking this steroid for a period of five months. Mr H was concerned about any long term effect that this medication error may have on his future health. Finally, Mr H complained that the Surgery failed to investigate his complaint in a thorough and unbiased manner.

The Ombudsman partly upheld the complaint. Having sought clinical advice, the investigation found that the Surgery was responsible for the prescription error. However, there was no evidence to suggest that this error was responsible for the side effects that Mr H had experienced within the past 5 years, including nose bleeds, persistent irritability and lethargy or that his recent hormone abnormalities could be attributed to this error or to his prolonged taking of the medication dexamethasone in 2004. There was no evidence to suggest that any long term hormonal problem was caused by this medication. However, the evidence showed that the Surgery failed to provide Mr H with adequate advice about the possibility of developing an infection and what steps he should follow in those circumstances once he had stopped taking the dexamethasone. There was

no evidence that the Surgery was biased in its consideration of Mr H's complaint although other inadequacies in handling Mr H's complaint were highlighted.
Case reference 201001777

June 2011 – Clinical treatment outside hospital – Aneurin Bevan Health Board
Ms S complained about the standard of care provided to her late brother, Mr S, by Aneurin Bevan Health Board's mental health services.

The Ombudsman found that there were some failings to the extent that the requirements of the Care Programme Approach were not met, and the service Mr S received when he tried to obtain treatment out of hours on one occasion was poor. Overall, however, the Ombudsman found that the standard of care Mr S received was largely adequate. The Ombudsman therefore partly upheld the complaint.

The Health Board had already carried out a thorough investigation which led to appropriate action being taken to improve services. The Ombudsman commended the Health Board for its response. He recommended that the Health Board should apologise to Mr S's family for the failings he had identified and also made some recommendations relating to the use of root cause analysis in incident investigations and reviewing the use of the Care Programme Approach once new guidance is issued by the Welsh Government. The Health Board accepted the Ombudsman's recommendations.
Case reference 201001722

June 2011 – Clinical treatment in hospital – Aneurin Bevan Health Board
Mr A complained about the former Gwent Healthcare Trust ("the Trust"), now part of the Aneurin Bevan Health Board ("the HB"). Mr A said that consultant surgeons mishandled treatment on his knee after he had an accident at work. He added that Trust clinicians failed to communicate properly with him thereafter. Mr A said that the Trust/HB did not handle his representations and complaints properly.

The Ombudsman upheld all of Mr A's complaints. He found that surgery on Mr A's knee in 2003 was not effective, although subsequent treatment was appropriate. The Ombudsman concluded that there were numerous, lengthy and significant failures in communications with Mr A. He said that complaint handling was poor. The Ombudsman recommended that the HB pay Mr A £1200 as an acknowledgement of the clinical and other failures that were apparent. The Ombudsman also made recommendations to improve the contribution of surgeons when staff are investigating patient concerns. The HB agreed to implement the Ombudsman's recommendations.
Case reference 201001090

June 2011 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board (UHB)
Following an accidental twist in which her knee gave way, 'A' (who has a history of injury to both knees) was admitted to Ysbyty Gwynedd on 19 January 2009. Following a number of clinical investigations, the First Consultant decided a conservative approach with physiotherapy was

the appropriate treatment option and A's discharge was planned for around 23 January. 'A' considered that her condition had not been properly diagnosed prior to this planned discharge. She also complained that she suffered with increasing pain but was encouraged to continue with physiotherapy. She requested a second medical opinion which she believed she had to fight for, and was made to feel a nuisance. 'A' received a second opinion on 24 January from the Second Consultant who later carried out an Arthroscopy procedure. 'A' considered that this had been the treatment which was required from the outset. 'A' also complained that there were shortcomings in the complaint handling process in that her complaint had not been responded to fully or accurately by the Health Board.

The Ombudsman did not uphold the complaints that there had been a delay in A receiving the correct procedure or that her planned discharge was inappropriate. A's complaint about the continuation of physiotherapy was also not upheld. The Ombudsman did uphold A's complaint that there were shortcomings in the process of her obtaining a second opinion and upheld her complaint about the failings in the Health Board's management of her complaint, specifically in terms of the fullness of its responses. Due to shortcomings in the recording of events at the time of the request for a second opinion, the Ombudsman could not make a judgement on the accuracy of the Health Board's responses. The Health Board was recommended to apologise to A, and confirm it has both an effective complaint handling procedure and a clear procedure for dealing with patient requests for a second opinion in place.
Case reference 201001354

May 2011 – Clinical treatment in hospital – Cwm Taf Health Board
In 2007, Mrs B, who had circulatory problems in her left leg, was being seen by doctors at the Royal Glamorgan Hospital ("the Hospital"). Mrs A, her daughter, subsequently complained:

(a) about the management of her mother's care following a bypass operation (using a prosthetic graft) on her left leg. In particular, she expressed concern about the lack of infection control when her mother had been left on the ward with an open wound. Mrs A believed that this had led to her mother getting a hospital acquired infection which delayed her recovery;
(b) about the former Cwm Taf NHS Trust and Cwm Taf Local Health Board's unsatisfactory responses to her complaint.

In relation to complaint (a), the Ombudsman's investigation concluded that Mrs B's care in terms of infection control and the management of her infection prior to 4 September 2007 was broadly in line with accepted practice. However, the Ombudsman considered that the failure to remove the infected prosthetic graft on 4 September 2007 when Mrs B's left leg was amputated compromised her recovery. The investigation also found shortcomings in record keeping. To that extent, the Ombudsman upheld this aspect of Mrs A's complaint. The investigation concerning complaint (b) found that there were inadequacies in how both the former Trust and the Health Board handled Mrs A's complaint.

In response to the failings identified above, the Ombudsman recommended that, within one month of the report being finalised, the Health Board should:

- apologise to Mrs A and Mrs B for the shortcomings identified in the report and pay £750 to Mrs B in recognition of the additional distress she had suffered after 4 September 2007;
- take action to ensure that all its staff appropriately maintained and updated all aspects of individual patients' records;
- apologise to Mrs A for the shortcomings identified in the report in relation to complaints handling. In addition, the Health Board should make a payment of £250 for the additional distress and inconvenience that the Trust/Health Board's shortcomings had caused Mrs A.

Case reference 201000180

May 2011 – Clinical treatment in hospital – Cardiff and Vale University Health Board (UHB)

Mrs P complained about the post-operative care provided to her husband, Mr P, following surgery for bowel cancer. In particular, she complained about the standard of infection control measures employed and the antibiotic treatment he received. Mrs P also complained about the standard of dietetic input Mr P received whilst in hospital. Mr P sadly died in January 2009.

The Ombudsman found that the overall standard of care in respect of infection control and treatment was reasonable. However, the Ombudsman concluded that there was an abject failure to assess, react to and implement solutions for Mr P's dietary problems.

The Ombudsman recommended that the Health Board should apologise to Mrs P for the failings identified in this report and should implement both audits and new procedures to address those failings.

Case reference 201001190

May 2011 – Clinical treatment in hospital – Aneurin Bevan Health Board

Mrs I complained about surgery undertaken on her late husband which she said ultimately resulted in his premature death from complications arising out of the surgery. Mrs I complained that her husband had not given proper consent for the surgery and that the operation was not carried out safely. Mrs I also complained about the overall standard of care her husband received during his post-operative hospital admission.

The Ombudsman partially upheld Mrs I's complaints, concluding that the consent process was inadequate and that the surgery could not be confirmed as having been carried out safely, on the basis of a failure to fully investigate the nature of Mr I's condition before proceeding with surgery. The Ombudsman concluded, however, that the overall standard of care Mr I received during his post-operative hospital admission was of a reasonable standard.

The Ombudsman recommended that the Health Board should apologise to Mrs I for the failings identified. Amongst other recommendations, the Ombudsman said that the Health Board should review its consent forms and also carry out an audit of the standard of the relevant surgeon's endoscopic reporting.

Case reference 201000408

May 2011 – Clinical treatment outside hospital – Abertawe Bro Morgannwg University Health Board (UHB)

Mr A had his right arm amputated in August 2004. He attended Swansea Artificial Limb & Appliance Centre (ALAC) from 2005 to 2009 with a view to obtaining a functional prosthetic arm. Swansea ALAC is part of Abertawe Bro Morgannwg University Health Board. Mr A complained that Swansea ALAC consistently failed to provide a prosthetic limb that fitted and worked properly and that the Health Board failed to provide adequate responses to his complaints.

As part of the Ombudsman's investigation, advice was obtained from two prosthetic specialists. The Ombudsman agreed with the advisers that it would have been beneficial for Mr A to have been seen at the start of his treatment by the consultant in rehabilitation medicine and the multi-disciplinary team. It was more than two years before Mr A met with the consultant. Since these events, the consultant routinely sees new patients. The Ombudsman concluded that ALAC failed to fit at least one of the prostheses so that it was functional and comfortable. In addition, different prescriptions should have been considered for the elbow as other types of elbow were available which may have better suited Mr A's needs. The Health Board agreed to implement the Ombudsman's recommendation that clinical staff review the investigation report and consider what lessons can be learnt from Mr A's case for the care of patients in the future

The Ombudsman upheld Mr A's complaint that the Health Board failed to provide adequate responses to his complaints. The Health Board became muddled between responding to Mr A's complaints and dealing with his on-going clinical care. The Health Board agreed to ensure that it has systems in place to deal fully with complaints, and that it is able, as far as is possible, to divorce complaints from on-going care issues.

Case reference 201000325

May 2011 – Appointments, admissions, appeals and discharge procedures

In 2007 Mr Y underwent an operation for the removal of bowel cancer. From September 2008 onwards, Mr Y suffered a series of urinary tract infections. A cystoscopy in February 2009 showed possible cancer spread into the bladder. Mr Y was then referred urgently to see the Consultant who had performed the surgery in 2007. Mrs Y complained that Mr Y had to endure a six week wait to be seen by the Consultant, despite his condition and medical history. Mrs Y considered that the unreasonable delay in seeing the Consultant contributed to the overall delay in Mr Y's treatment which eventually led to him being too weak to undergo surgery. Sadly, he subsequently died. Mrs Y also complained about poor communication on the part of the LHB's staff.

Having sought clinical advice from two of the Ombudsman's professional advisers, the investigation found that, in view of Mr Y's condition and medical history, a six week wait to see the Consultant following an urgent referral was not acceptable. It was impossible to say what clinical effect the delay had but it caused considerable distress to Mr Y and his family. The complaint was upheld. The Ombudsman recommended that the LHB apologise to Mrs Y for the delay and demonstrate to her the action it said it has since taken to ensure that such delays do not recur.

With respect to the complaint about poor communication, the investigation found that the LHB had taken an unduly long time to provide the test results to Mr Y, and this caused additional uncertainty and distress to Mr Y and his family. There was otherwise insufficient evidence to conclude that communication on the part of the LHB's staff had been maladministratively poor. This complaint was therefore upheld in part. The Ombudsman recommended that the LHB apologise to Mrs Y for the time taken to provide the test results.

The LHB agreed to implement the recommendations.
Case reference 201000105

May 2011 – Clinical treatment in hospitals – Hywel Dda Health Board
Mrs C complained about the general standard of nursing care her late husband received whilst in hospital, including issues surrounding her husband being left in a soiled bed and the failure of nursing staff to communicate with her effectively with regard to her husband's treatment. Mrs C also complained about clinical decisions taken with regard to the management of her husband's supra-pubic catheter, which she said should have been changed when it failed to function properly, rather than being washed out and a temporary urethral catheter inserted.
Mrs C also complained about a failure to diagnose an incarcerated femoral hernia, which was listed on her husband's post-mortem report. She also complained about a failure on the Health Board's part to properly investigate her complaint about her husband's care on the evening before his death.

The Ombudsman did not uphold Mrs C's complaints in their entirety. The Ombudsman found that, whilst there were examples of good nursing, there were a number of issues of concern where the standard of nursing care fell below a reasonable standard. The Ombudsman found that the failure to diagnose the hernia was not due to any clinical failings on the part of medical staff. The Ombudsman found that the Health Board's investigation into certain aspects of Mrs C's complaint was incompetent.

The Ombudsman made a number of recommendations, which included asking the Health Board to carry out reviews of the standard of recordkeeping and communication on the ward involved and in respect of the standard of its internal complaint investigations.
Case reference 201001484

May 2011 – Clinical treatment in hospital – Aneurin Bevan Health Board
Miss G complained about a hospital managed by Aneurin Bevan Local Health Board ("the HB") regarding numerous issues concerning the last hours of her labour, the birth of her baby and her care in the days that followed. She said that her care ruined what should have been special days in her life.

The Ombudsman upheld many of Miss G's complaints but not all of them. Among the findings were that Miss G did not have the level of midwifery care that she had a right to expect during the last hours of her labour; was not supported as she should have been whilst taking a shower a few days later; did not have a thorough de-briefing after the difficult labour and birth and her

subsequent complaint was not handled as quickly as suggested by the relevant guidance. The Ombudsman made a number of recommendations to the HB, including paying Miss G £600 as an acknowledgement of her distress, various process reviews and the introduction of a new de-briefing policy. The HB accepted his recommendations.
Case reference 201001059

Not Upheld

June 2011 - Clinical treatment outside hospital – GP in Abertawe Bro Morgannwg University Health Board area
Mr D Jnr complained about the care and treatment that was provided to his father, Mr D Snr, by a GP in the Health Boards area. Mr D Jnr believed that the GP failed to take a proper history and to arrange appropriate tests in light of his father's presenting symptoms during his consultation in February 2010. As a result, Mr D Jnr complained that the GP failed to diagnose his father's cancer at an earlier stage. He also complained about the manner in which his father was informed of his blood test results.

The Ombudsman did not uphold the complaints. Having sought clinical advice, the investigation found that the examination, history and further tests arranged by the GP were appropriate. There was nothing in Mr D Snr's presenting symptoms to suggest that specific investigations for cancer should have been carried out at the time. The investigation found that it is normal practice for patients to be informed of blood tests results by a non-clinical member of staff in circumstances where they are reported as normal or satisfactory. Therefore, it was appropriate that when Mr D Snr contacted the Surgery to obtain his blood test results, a member of the Surgery's reception staff informed him that his blood tests had reported as normal.
Case reference 201001856

June 2011 – Clinical treatment in hospital – Cwm Taf Health Board
Mr & Mrs A's son suffered with SSPE (Subacute Sclerosing Panencephalitis), a rare complication following measles. They complained about the care given to their son following his admission to hospital, a few weeks before his death. They said that he had been given his usual pre-digested feed, shortly after admission, against their advice and this had made his condition worse. They were also aggrieved that the decision not to resuscitate their son (DNAR) had not been discussed with them as a family.

After taking account of advice from one of his medical advisers, the Ombudsman found that there was no evidence that Mr & Mrs A's son had been fed as suggested and it was unlikely that further enquiries would result in any firm conclusions. The DNAR decision was recorded appropriately by the Consultant taking care of their son and medical records indicated that this was discussed with members of the family, who disagreed with the decision. Ultimately the final decision rested with the consultant in charge of their son's care. The Ombudsman accepted the view of his Adviser that, overall, the decisions taken were not unreasonable in the circumstances of this case. Mr & Mrs A's complaint was not upheld.
Case reference 201001302

May 2011 – Clinical treatment in hospital – Conwy and Denbighshire NHS Trust (now Betsi Cadwaladr University Health Board) & a GP Practice in Betsi Cadwaladr UHB area
Mrs C made a complaint about the standard of care provided to her late father, Mr D, by both his GP Surgery and the Health Board. She complained that Mr D was admitted by the GPs to the local Community Hospital which was inappropriate for his condition. He was then transferred to the District Hospital and Mrs C raised concerns that insufficient urgent investigations were done into Mr D's condition. She also complained about his pain management and nutrition. Finally, she was concerned that the family were not kept informed of the severity of his illness. Eventually the diagnosis of mesenteric ischemia was reached but sadly Mr D died very soon after.

Having obtained independent clinical advice, the Ombudsman concluded that it was reasonable for the GPs to admit Mr D to the Community Hospital and the care provided to him there was appropriate. He therefore did not uphold the complaint against the GP Surgery.

In relation to the complaint against the Health Board about Mr D's hospital care, the Ombudsman found that appropriate and timely investigations into Mr D's condition were carried out. It was acknowledged that mesenteric ischemia is a difficult condition to diagnose. He also concluded that the communication with the family was acceptable. Whilst the pain relief given to Mr D was not unreasonable, the Ombudsman suggested that involvement of a pain specialist in Mr D's care would have enabled more effective management of his fluctuating pain levels. The Ombudsman also expressed concern about Mr D's nutritional intake as it was noted that he had lost a considerable amount of weight and was seriously underweight. The Ombudsman's clinical adviser's view was that additional feeding, such as parenteral feeding (whilst ultimately it may have been unsuitable for Mr D) should have been considered. The Ombudsman therefore upheld the complaint against the Health Board to a limited extent.
Case reference 201000579 & 201000589

May 2011 – Clinical treatment in hospital – Cardiff and Vale University Health Board (UHB)
Mr DE and his son, Mr TE, complained that Mrs E (Mr DE's wife and Mr TE's mother) was inappropriately sent home from A&E on 31 May 2009. She suffered from Chronic Obstructive Pulmonary Disease (COPD – obstruction to the airflow). She returned to A&E the following day and was admitted to intensive care (ITU). She sadly died there in July 2009. Mr DE and Mr TE also complained that a meeting to discuss the withdrawal of life support was brought forward from Monday 6 July to Sunday 5 July. This did not give the family a chance to come to terms with what was happening, and Mr TE was upset to find his mother fully conscious when he went in to see her for the last time.

Having taken clinical advice from two independent clinicians, the Ombudsman did not uphold either complaint. He found that the decision to discharge Mrs E from A&E was soundly based after tests and examinations had been carried out. He further found that, while the family were understandably distressed about the events surrounding the withdrawal of life support from Mrs E, it had been reasonable to bring the meeting forward, and it was reasonable not to sedate Mrs E as that was not clinically necessary at that time.
Case reference 201000493

May 2011 – Clinical treatment in hospital – Abertawe Bro Morgannnwg University Health Board (UHB) and GP in Abertawe Bro Morgannwg UHB area
Mr B complained about clinical treatment that he received from Abertawe Bro Morgannwg UHB ("the HB") and its predecessor body and his GP, in the period from 2008-2010. Mr B said that hospital clinicians and his GP did not respond appropriately to his presentations and symptoms relating to recurrent abscesses in his groin area. He maintained that they effectively ignored his pleas and, therefore, a large abscess remained untreated for a long time. Mr B stated that he suffered needlessly.

The Ombudsman found that hospital staff of the HB, and its predecessor, generally provided adequate treatment to Mr B. However, he identified some failings, which he concluded were not severe and did not greatly affect Mr B's condition. That being the case, he decided that he could not uphold the complaint. However, the HB confirmed that it would address the Ombudsman's concerns about this case. The Ombudsman found no fault with the GP's care of Mr B and did not uphold that complaint.
Case reference 201000936 & 201001082

May 2011 – Clinical treatment outside hospital – Aneurin Bevan Health Board
Mr S complained about the care of his wife, who was being treated for bipolar affective disorder. He was particularly concerned about changes to her medication regime and the long-term use of Diazepam. He said that doctors were not listening to his concerns.

The Ombudsman found that the treatment given to Mrs S was not unreasonable. Mrs S's medication had been changed because of the side effects of her main drug and appropriate alternative medication introduced. (Diazepam was started to deal with Mrs S's levels of anxiety which had been difficult to treat although variable doses had been tried over the years.) The Ombudsman's view was based on clinical advice that the changes in medication had been to try to ameliorate symptoms as they presented and to minimise side effects. He was guided by the adviser's view that all doses of medication used were acceptable and within the recommended range. Also while long term use of diazepam was not ideal, there was no practical alternative in Mrs S's case and to stop it completely could have had a greater impact.

The Ombudsman did not uphold the complaint, although he noted that better explanations should have been given to Mrs S and should have been recorded. Overall, these more minor shortcomings did not affect his finding.
Case reference 200901089

April 2011 – Clinical treatment in hospital – Cardiff and Vale University Health Board
Mr T complained that A & E staff at a hospital under the management of the LHB, asked him to leave the premises without offering treatment during an evening in 2010. He said that staff were generally unsympathetic and over-reacted to his behaviour, which he admitted involved shouting and swearing. He stated that he had a very severe headache that explained his presentation. Mr T added that staff did not help him and then made him leave with security staff after he "lost it". Mr T added that the LHB's complaint response amounted to "blackmail" as it insisted that he was welcome to future services but only if he behaved properly.

The Ombudsman found that there was no evidence that staff acted unreasonably or outside of LHB policy, despite the obvious distress that Mr T had experienced concerning the event. He also concluded that the complaint response letter was appropriate. The Ombudsman did not uphold Mr T's complaints.
Case reference 201001685

Planning and Building Control Summaries

Not Upheld

June 2011 – Handling of planning application – Wrexham County Borough Council
Mr S complained that he had not been consulted about a planning application for a development on a site which adjoined his own property. He said that he had not received a neighbour notification letter which the Council said it had sent him and that any site notice that may have been displayed must have been removed. Mr S complained that the development was too close to his property and that it affected his privacy and amenity.

The Ombudsman was satisfied that the Council had provided evidence that appropriate consultation had been undertaken. Furthermore, the Ombudsman's professional adviser said that the planning application had been determined in accordance with policy and that he could see no grounds for planning permission to have been refused. The Ombudsman did not therefore uphold the complaint.
Case reference 201002523

Environment and Environmental Health

Not Upheld

May 2011 – Other – Countryside Council for Wales
In 1990, Mr M's father entered into a management agreement for a site of special scientific interest on his land. As part of the management agreement, Mr M's father (and later Mr M) agreed not to carry out certain activities on the land covered by the SSSI in return for an annual payment.

Mr M complained that the Countryside Council for Wales (CCW) had refused to renew the management agreement on the basis it had previously operated when it came up for renewal in 2009. Specifically, CCW was offering a smaller annual payment in return for Mr M entering into the agreement.

The Ombudsman found that, whilst the amount being offered by CCW was less than under the previous management agreements, it was in line with amounts paid to landowners with similar agreements and in compliance with the relevant legislation and guidance. The Ombudsman did not uphold the complaint.
Case reference 201001508

Housing Summaries

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

June 2011 – Applications, allocations, transfer and exchanges – Isle of Anglesey County Council
Ms A's complaints concerned how the Council dealt with her housing applications and the affordability of her current temporary accommodation. In early 2000, when Ms A was a private sector tenant, she applied to the Council for housing. She said that she had made a number of contacts with Housing Services over the years to try and progress her applications and had raised issues of overcrowding, disrepair and anti-social behaviour. Ms A complained about the length of time she had been waiting to be offered a Council house, particularly as the Council had accepted that it owed her a full homelessness duty in November 2004. Ms A was placed in temporary accommodation from June 2009. She complained that she was not made aware that the charge for her accommodation was likely to increase as a result of funding changes.

The investigation found serious shortcomings in the way that the Council dealt with Ms A's homelessness and housing applications. Although the Council accepted that it had a homelessness duty towards Ms A, there was no evidence that she was formally offered temporary accommodation before June 2009. The Council subsequently misfiled her homelessness application and it was not progressed for a period of four and a half years. In addition, the Council repeatedly failed to consider all of the available information relevant to Ms A's housing applications in accordance with its Allocations Policy. This led to her not being offered a Council property in September 2005. The investigation also uncovered serious deficiencies in the Council's record keeping. Whilst recognising the Council's later efforts to minimise the impact on applicants of increased charges for its temporary accommodation, the Ombudsman felt that the Council should have had greater regard, at an earlier stage, to its Homelessness Strategy. This was particularly relevant for working applicants who might not qualify for housing benefit.

The Ombudsman found systemic maladministration. He recommended that the Council apologise to Ms A and her family for its failings, and offer her a redress payment of £1500. He also made a number of recommendations for further action by the Council, including the production of up-to-date written procedures on housing allocations and homelessness and further training for relevant officers.
Case reference 200902138

Adult Social Services Summaries

Upheld

June 2011 – Services for vulnerable adults – Blaenau Gwent County Borough Council
Mrs M's complaint related to how the Council had dealt with her mother ("JH") about whom the family had made a referral to the Council under Protection of Vulnerable Adults (POVA) procedures. She complained that the Council did not follow POVA procedures /policy correctly; did not investigate the POVA referral properly/in a timely manner; and, delayed in the investigation of Mrs M's subsequent complaint about the Council's handling of the POVA referral. Mrs M also felt that the Council's Stage 2 complaints investigation was not sufficiently thorough.

Following advice from the Ombudsman's Adviser on Social Services matters, the complaint was partly upheld. Whilst a POVA strategy meeting took place a few days later than it should have done, given the need to involve the police, it was felt that this did not unduly prejudice Mrs M (and JH was already in a place of safety). Nevertheless, shortcomings were identified, including: missing records of discussions; missing minutes and file records; and typographical errors. All collectively demonstrated a failure to adhere to procedures and detracted from the credibility of some documents. An unacceptable delay occurred in the appointment of the Stage 2 complaints investigator. Whilst the investigation report overall identified some shortcomings and made good recommendations, the typographical errors within it also detracted from its credibility. The Adviser further identified additional failures on the part of the Council, as well as concerns about the Care Programme Approach (CPA) implementation.

The Ombudsman recommended that the Council apologise to Mrs M for the failures. He also asked for the Council's assurance that the Stage 2 recommendations had been implemented, as well as assurance about refresher POVA training for relevant staff. The Council agreed to the recommendations.
Case reference 201000046

Children's Social Services Summaries

Upheld

May 2011 – Inaccuracies in assessment process - The City and County of Swansea
Mrs Y complained about issues arising from the Council's assessment of her daughter's needs for the provision of a wobble board and assistance with swimming lessons. She said that the core assessment was based on an inaccurate note of a meeting at her daughter's school. Following a referral from a consultant about her daughter's medical condition, she was also unhappy with the investigation of her complaints under the statutory complaints procedure about further assessment which was carried out. She said that the investigation took too long, was lacking in impartiality and failed to examine the relevant points. The Council had also not liaised with the NHS about the provision of the service.

The Ombudsman found that it was impossible to reach firm conclusions about what was said at the meeting at the school, which had taken place in 2006. However, there were shortcomings in the initial assessment which followed because further information had not been obtained from the school or health. The Ombudsman's view was that issues should have been pursued with other agencies or shared at a 'Child in Need' meeting to facilitate a holistic approach. Following the decision not to provide a service, the Council delayed for several months before it asked for consent to refer the case to health, but any subsequent delay was down to Mrs Y's refusal to provide consent.

The Ombudsman was critical of the Council's complaint-handling for the length of time taken to investigate the complaint. A second 'Stage 2 investigation' was only necessary because of poor complaint handling and was carried out by the same investigator; however, it would have been good practice to appoint another investigator who was not familiar with the case. The shortcomings in the assessment had not been highlighted by the independent investigator in his report.

Overall, the Ombudsman found maladministration but he could not say that the Council would have provided a service if the shortcomings had not occurred. Mrs Y's daughter has since been reassessed as an adult.

The Council agreed to apologise and make a payment of £250 for the time and trouble in making the complaint. It was also required to remind its staff of the need to consult other agencies and, where it was necessary to make referrals to other agencies, to do so as quickly as possible.
Case reference 200902417

April 2011 – Child protection – Denbighshire County Council
Mr X complained about the way the Council considered child protection allegations made against him. In particular, Mr X argued that the Council had failed to consider whether the allegations were malicious or designed to harass him. He also complained that he was not notified of the outcome of a strategy meeting within the relevant timescales; that an officer of the Council refused to provide advice over the telephone; and that his subsequent complaints were not dealt with properly.

The Ombudsman found that the Council had considered whether the complaints were malicious and/or designed to harass Mr X. He also found that an e-mail was sent to Mr X within the relevant timescales to notify him of the outcome of the strategy meeting; however, for some reason, Mr X did not receive it until the next day. The Ombudsman did not uphold these parts of Mr X's complaint. The Ombudsman made no finding about the actions of the Council officer as it was her word against Mr X's. Finally, while the Ombudsman found that the consideration of Mr X's complaint was generally sound, there were some very minor failings. He partly upheld this aspect of Mr X's complaint and recommended that the Council apologise to Mr X.
Case reference 201000572

April 2011 – Child protection – Cyngor Sir Ceredigion
Mr & Mrs P complained about the way in which the Council carried out child protection enquiries into allegations made by their daughter; the way in which the Council's Social Services Department dealt with their daughter's welfare; and the way in which the Council communicated with Mr & Mrs P about their daughter. Mr & Mrs P were also dissatisfied with the investigation of their complaint under stage 2 of the Social Services Complaints Procedure.

The Ombudsman found that, in general, the actions of the Council were reasonable and in accordance with relevant procedures and guidance. The Ombudsman made some limited criticisms of the Council: in particular, that a strategy meeting was not held following an initial allegation by Mr & Mrs P's daughter and that some elements of communication with Mr & Mrs P could have been better.

The Ombudsman partly upheld the complaint to the extent of the limited failings identified. The Council agreed to remind relevant staff of the importance of convening strategy meetings where appropriate, and of the need to inform parents of looked-after children when their child's allocated worker had changed.
Case reference 201000544

More Information

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

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

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