Our ref: MG/jm
Ask for: James Merrifield

Your ref:
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Date: 15 July 2014
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Professor Trevor Purt
Chief Executive
Betsi Cadwaladr University LHB
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Dear Professor Purt

Annual Letter 2013/14

Following the recent publication of my Annual Report, I am pleased to provide you with the Annual Letter (2013/14) for Betsi Cadwaladr University Health Board.

As set out in the Annual Report, the past year has seen a continuation of the upward trend in enquiries and complaints received by my office. Health complaints are again the most numerous type of complaint, with such complaints now having increased by 146% over the past five years. Whilst there are likely to be a number of reasons for such an increase, it has to be concluded that it is also an indication that increasingly health service delivery, and furthermore health complaint handling, is not what it should be.

In reference to the overall performance of health boards in Wales, my office has issued more reports in which the complaint was upheld, and fewer reports in which the complaint was not upheld, compared with 2012/13. The figures show that the largest number of health complaints again relate to clinical treatment in hospital, whilst there have also been noticeable increases in the numbers of complaints about appointments, admissions, discharges and transfer procedures, as well as continuing care.

I issued nine public interest Reports in 2013/14, the majority of which related to health complaints. These reports identified serious failings in respect of the following:

- acting in accordance with national guidelines for the treatment of stroke;
- making reasonable adjustments to accommodate a patient's deafness;
- the implementation of guidelines designed to prevent misdiagnosis of early pregnancy loss;
- treatment in respect of cirrhosis;
- treatment provided by an Out of Hours GP;
- dealing with a patient's condition on arrival at an Accident and Emergency Department;
- incomplete records, leading to a lack of clarity over whether a patient had received medication for Parkinson's disease; and,
- significant maladministration in two continuing care assessments.

Clearly, these failings are diverse in their nature. I would encourage all health boards to consider the lessons from these cases and the recommendations made; look at your own practices and satisfy yourselves that your own arrangements for service delivery in these areas are appropriate and that your staff are suitably trained.

In considering other outcomes, it is worth noting an increase in the levels of 'Quick Fixes' and 'Voluntary Settlements', in comparison to 2012/13. In view of the increasing level of health complaints, the benefits of resolving certain types of complaints quickly, without the need for a full investigation, should not be underestimated. I am encouraged that health boards are co-operating in achieving these types of resolutions.

In reference to the amount of time taken by public bodies in Wales in responding to requests for information from my office during 2013/14, whilst there has been an increase in the percentage of responses received within four weeks, 36% of responses from public bodies have taken more than 6 weeks. I have outlined my concerns in the Annual Report over the way in which complaints are handled, and have also previously referred to 'delay', and the consequences of it, in The Ombudsman's Casebook. Clearly, there remains work to do to ensure that public bodies are providing information promptly and I urge all bodies to consider whether their performance in this area warrants further examination.

In reference to your Health Board, there has been a slight increase in the number of complaints received, compared with 2012/13. The largest single area of complaint remains 'clinical treatment in hospital', which is significantly above the health body average. There has been a noticeable increase in the number of complaints investigated, compared to 2012/13. My office has had reason to issue two Public Interest Reports against your Health Board during 2013/14, the summaries for which are enclosed. I would also urge you to familiarise yourself which the other enclosed summaries, in order to ensure that your Health Board is able to assist my office in resolving any suitable complaints by way of quick fixes or voluntary settlements. It is concerning to note that 70% of your Health Board's responses took more than six weeks.

I have copied this correspondence to the Chair of your Health Board with the intention that it be considered by the Board. The new Ombudsman will be taking up his post in August and I am sure he will be in touch at an appropriate time to introduce himself and to discuss some of the above matters. Finally, following the practice of previous years, a copy of the annual letters issued to health boards will be published on the PSOW's website.

Yours sincerely

Professor Margaret Griffiths
Acting Ombudsman

Copy: Chair, Betsi Cadwaladr University Health Board

Appendix

Explanatory Notes

Section A compares the number of complaints against the Health Board which were received by my office in 2013/14 with the average for health bodies (adjusted for population distribution) during the same period.

Section B provides a breakdown of the number of complaints received by my office, broken down into subject categories.

Section C compares the number of complaints against the Health Board received by my office during 2013/14, with the average for health bodies during this period. The figures are broken down into subject categories.

Section D provides the number of complaints against the Health Board which were taken into investigation by my office in 2013/14.

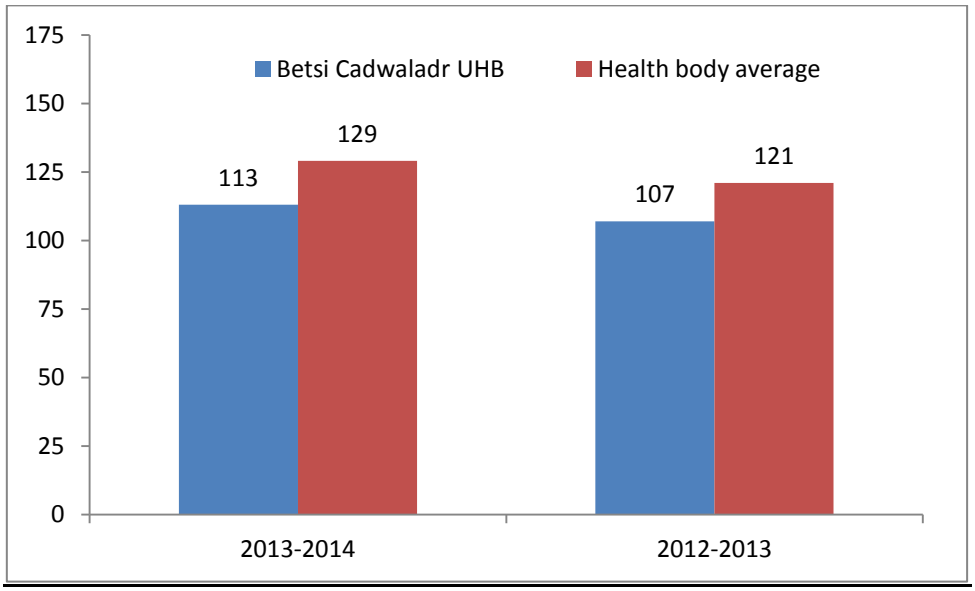
Section E compares the number of complaints against the Health Board which were taken into investigation by my office in 2013/14, with the average for health bodies (adjusted for population distribution) during the same period.

Section F compares the complaint outcomes for the Health Board during 2013/14, with the average outcome for health bodies during the same period. Public Interest reports issued under section 16 of the Public Services Ombudsman (Wales) Act 2005 are recorded as 'Section 16'.

Section G compares the Health Board's response times during 2013/14, with the average response times for health bodies, and the average for all public bodies in Wales during the same period. This graph measures the time between the date my office issued an 'investigation commencement' letter, and the date my office receives a full response to that letter from the public body.

Finally, Section H contains the summaries of all reports issued in relation to the Health Board during 2013/14.

A: Comparison of complaints received by my office with average for health bodies

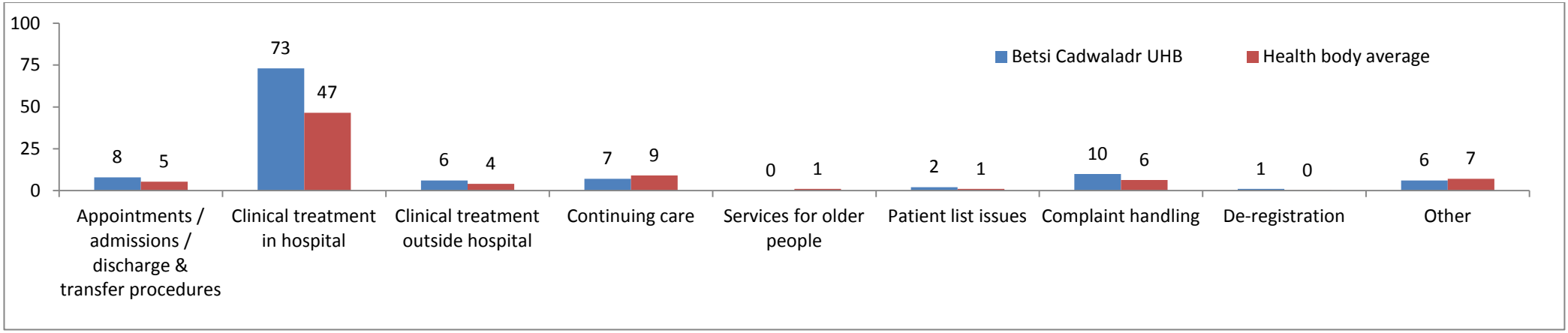


B: Complaints received by my office

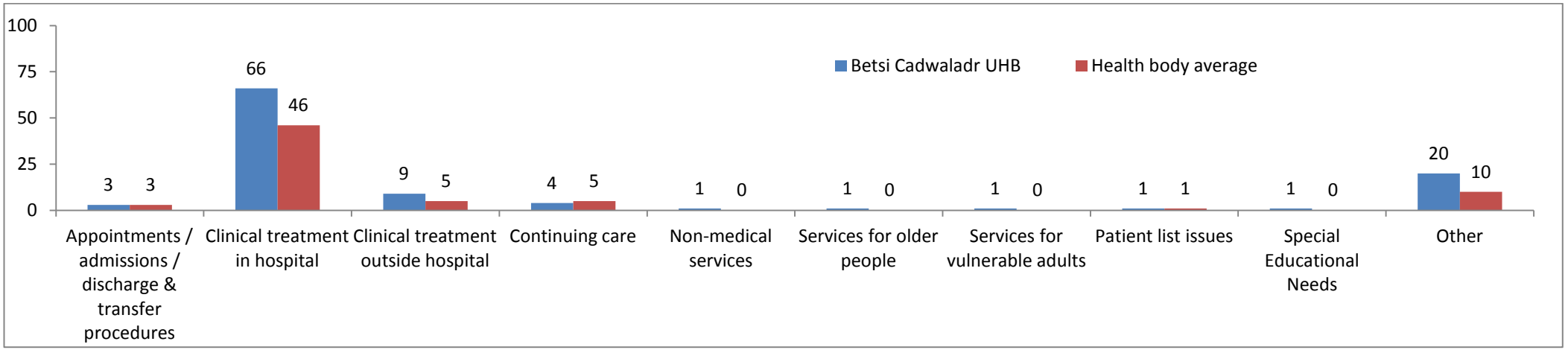
Subject	2013/14	2012/13
Appointments/ Admissions/ Discharge and transfer procedures	8	3
Clinical treatment in hospital	73	66
Clinical treatment outside hospital	6	9
Continuing care	7	4
Non-medical services	0	1
Services for older people	0	1
Services for vulnerable adults	0	1
Patient list issues	2	1
Complaint-handling	10	0
De-registration	1	0
Special Educational Needs	0	1
Other	6	20
TOTAL	**113**	**107**

C: Comparison of complaints by subject category with average for health bodies

2013/14



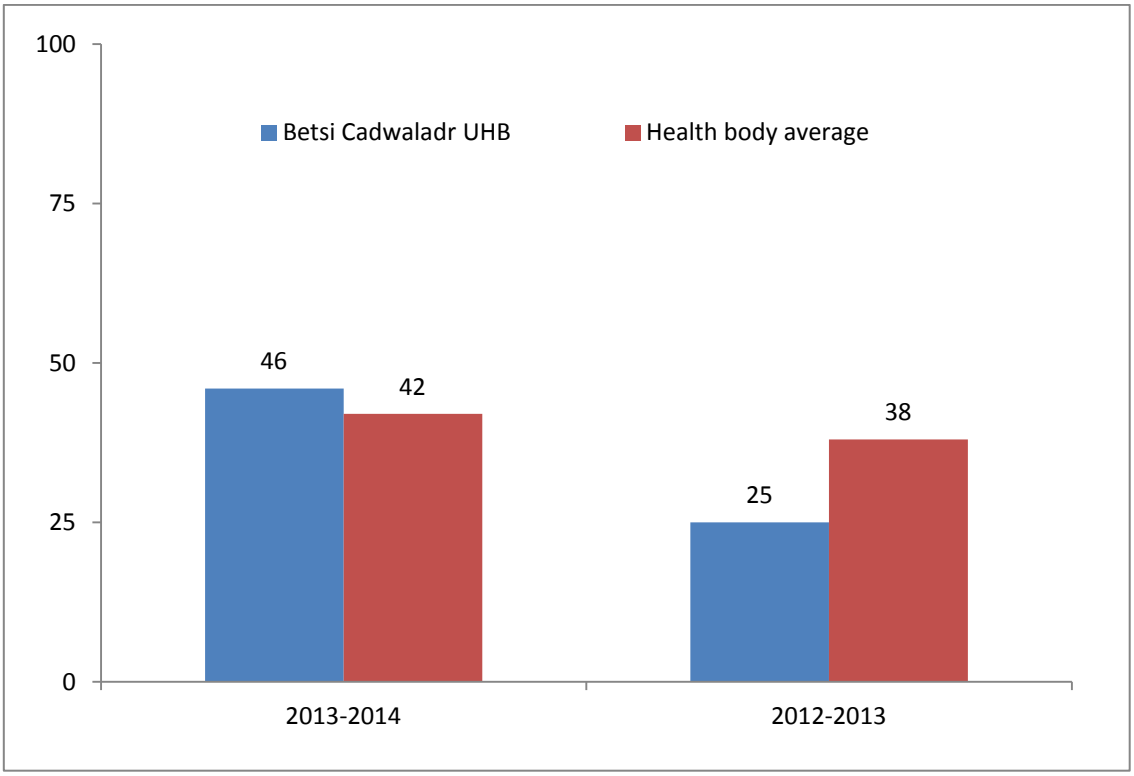
2012/13



D: Complaints taken into investigation by my office

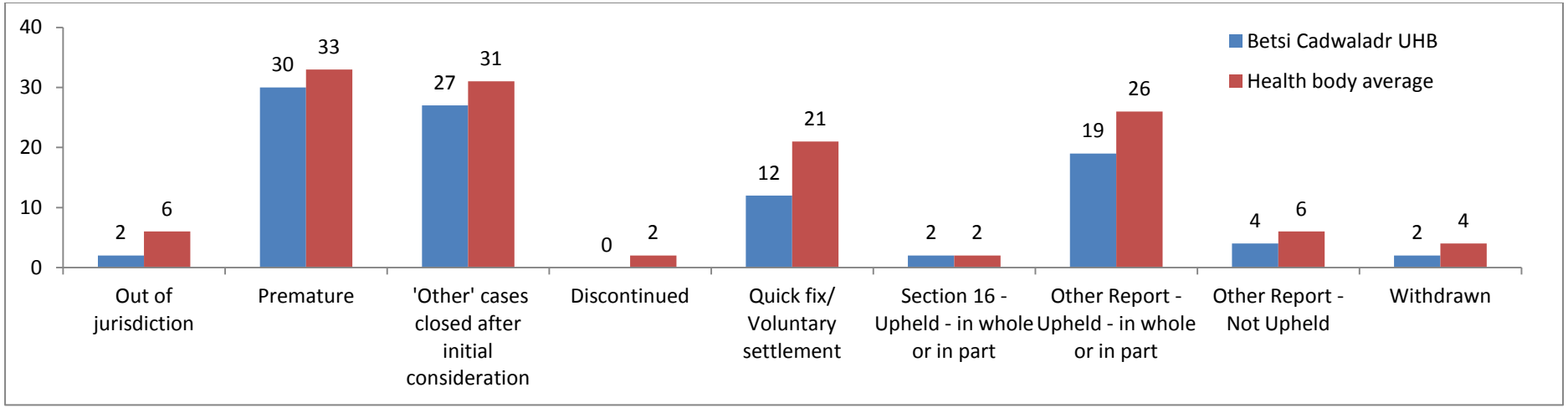
	2013/14	2012/13
Number of complaints taken into investigation	46	25

E: Comparison of complaints taken into investigation by my office with average for health bodies

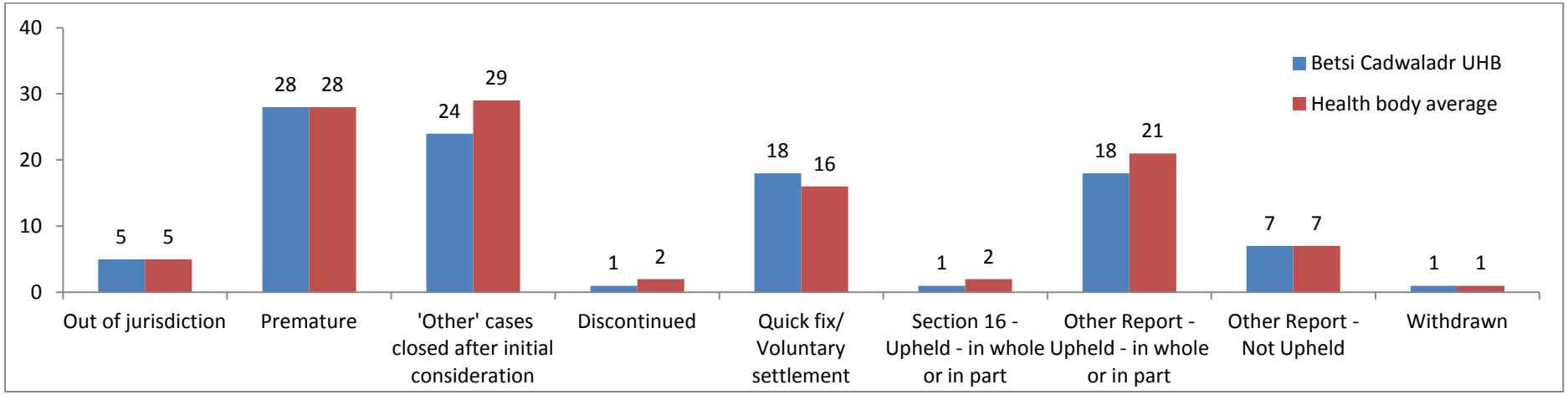


F: Comparison of complaint outcomes with average outcomes for health bodies, adjusted for population distribution

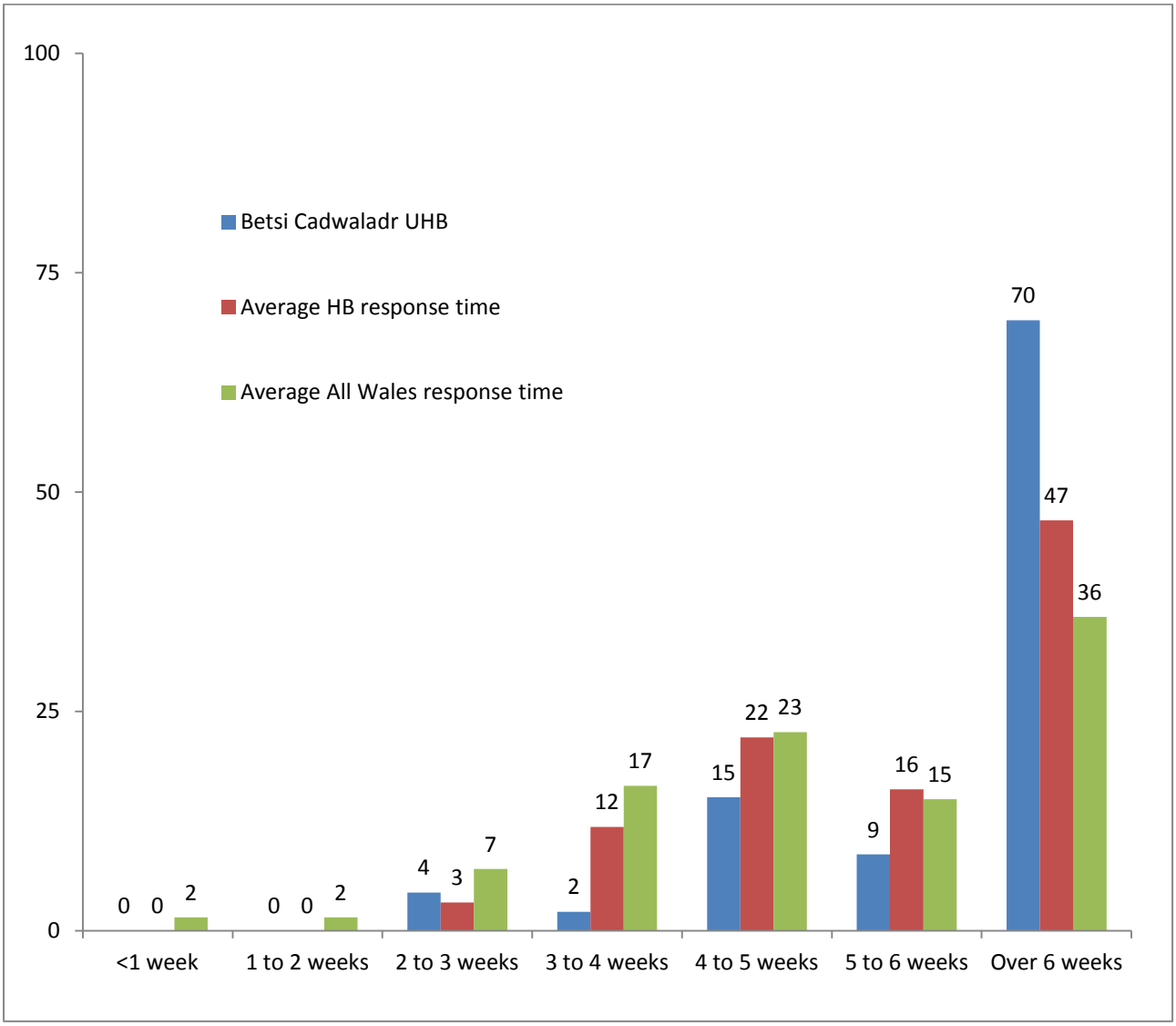
2013/14



2012/13



G: Comparison of Health Board times for responding to requests for information with average for health bodies and All Wales response times, 2013/14 (%)



H: Summaries

Public Interest Reports

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201201954 – Report issued October 2013
This complaint is about the shortcomings in the care and treatment provided to Mr X at Glan Clwyd Hospital. In November 2000 Mr X had his first episode of bleeding from enlarged blood vessels in the gullet. This is a life-threatening complication of cirrhosis, a condition in which healthy liver tissue is gradually replaced with non-functioning scar tissue. The vessels were tied to prevent further bleeding. Several tests were carried out over the next few months. They showed clearly that Mr X had cirrhosis. Despite this, he was not informed of the diagnosis. Nor was he given necessary lifestyle advice. In September 2001 the hospital apparently made him an outpatient follow-up appointment, but Mr X was not told about this. This meant that Mr X was without any medical supervision for several years, with no information about his condition. As it happens, that probably made little difference to how his condition developed.

Mr X had further bleeding in August 2008. Again this was treated successfully, although for a while he was very unwell. This time Mr X received medication and some, but not all, of the necessary lifestyle advice. The Health Board also began investigating the cause of Mr X's cirrhosis, but stopped before finding it. Not until he requested, and received, a second opinion was Mr X told that he had been born with cirrhosis.

In 2010 Mr X returned to hospital several times in quick succession. He looked very unwell. Blood tests showed that his liver was failing. Despite this, the hospital sent him away, only finally admitting him three days after his appearance. By then Mr X was in liver failure and had a serious infection. Mr X rapidly deteriorated and he sadly died, aged 30, seven weeks later.

Had he been treated three days earlier, Mr X should have recovered from the infection and had a chance of receiving a liver transplant. This opportunity to survive and flourish was denied to him.

The Ombudsman upheld the complaints that were made tohim. The Health Board subsequently agreed to my recommendations that it write to the family to acknowledge the failings and provide financial redress to Mr X's family; £5,000 in respect of the failings identified in Mr X's care and treatment plus a further £500 for the poor complaint handling. The Health Board also agreed to review the care pathway and its appointments system. The Consultant in charge of Mr X's care also agreed to consider the issues raised in the investigation and learn from these.

July 2013 - Clinical treatment in hospital - Betsi Cadwaladr University Health Board
Mr and Mrs Q complained about the care and treatment Mr Q had received as a patient at Glan Clwyd Hospital and Wrexham Maelor Hospital.

Having reviewed the evidence, the Ombudsman found that during Mr Q's admission to Glan Clwyd Hospital on 17 and 18 May 2011 the "In-Patient Medication Administration Record" had not been appropriately completed. As a result, it was unclear whether Mr Q had received any of his Parkinson's disease medication.

With respect to Mr Q's discharge from Wrexham Maelor Hospital on 22 May 2011, the Ombudsman found that the medical records for this period failed to fully reflect Mr Q's anxious and difficult behaviour, the actions taken by staff to reassure him, any medical reviews undertaken by doctors or need to call a security officer. As a result Mr Q was discharged from hospital without assessment, placing Mr and Mrs Q in a vulnerable position.

The Ombudsman recommended that the UHB apologise to Mr and Mrs Q for the failings identified in the report and pay them £750 in recognition of the service failure and the time and trouble in bringing their complaint to this office. The Ombudsman also recommended that the UHB:

- review Mr Q's "In-patients Medication Administration Record" for the period 17-18 May 2011, and where appropriate instigate the UHB's "Medicines Management Assessment Workbook and Competencies" document, in accordance with the UHB's procedure.
- review Mr Q's medical records for the period 19-22 May 2011 and where appropriate take action in accordance with the UHB's procedures.
- remind the relevant staff that in the event that a security officer is called an "Incident Recording Form" should be completed.
- bring the updated discharge protocol to the attention of the relevant staff and introduce discharge drop in sessions at the Second Hospital.
- produce a training plan ensuring that within 12 months all relevant staff at the Hospital receives training on record keeping.

Case reference 201201275

Upheld

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201204684 – March 2014

Mr Y complained about the care and treatment that his late wife received at Ysbyty Gwynedd. He was of the view that Mrs Y was given excessive oxygen at the Emergency Department in 2011 which led to Mrs Y requiring intensive care and ventilation. Mr Y also said that whilst Mrs Y was in the Intensive Care Unit there was a failure to adequately monitor the antibiotic gentamicin which subsequently led to Mrs Y suffering with renal failure. Finally Mr Y expressed concern about the Health Board's complaint responses.

In reaching her conclusions the Ombudsman took into account the clinical advice provided by four of her professional Advisers.

The Ombudsman found that there was no evidence that Mrs Y received the necessary blood gas testing in the Emergency Department. She concluded that this shortcoming probably led to Mrs Y receiving an inappropriate volume of oxygen and likely caused her to need slightly earlier ventilation than would otherwise have been the case. She was of the view however that this intervention would have been required at some stage due to the underlying nature of Mrs Y's condition. The Ombudsman was concerned that the incident must have been distressing to Mr and Mrs Y and highlighted that with better management there might have been a little more time to adjust to the circumstances they were almost inevitably facing. To that extent the Ombudsman upheld this element of the complaint.

In relation to the monitoring of the antibiotic, the Ombudsman found that although this medication may have played a part in Mrs Y's deterioration that there was nothing to suggest that the actions taken by the clinicians had been unsatisfactory. She noted that on the whole this medication was reasonably managed and that Mrs Y's kidney function had been adequately considered. The Ombudsman did not uphold this element of the complaint.

The Ombudsman partially upheld the complaint about the Health Board's complaint response. She concluded that although the responses were not wholly unreasonable, it was a shortcoming that the problem with blood gas testing had not been highlighted. She was also of the view that a meeting should have been arranged in line with the 'Putting Things Right' framework.

The Health Board agreed to implement the following recommendations:

1. apologise to Mr Y for the shortcomings in the care provided to Mrs Y during the period she was treated at the Emergency Department and for the limitations in its complaint response;

2. provide financial redress of £400 to Mr Y in light of the shortcomings;

3. introduce additional guidance to medical staff to increase their awareness of national guidelines along with the specific need for arterial blood gas

analysis in patients with respiratory disease presenting as an emergency with shortness of breath.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201204283 – Report issued March 2014
Mr S complained about his management and care following his emergency admission to hospital with suspected appendicitis. In particular, his complaints centred on the following: a delay in being seen by a doctor at the ED; a delay in being administered pain relief, both at the ED and later the following morning on a ward, a lack of monitoring; a delay in being seen by a Consultant and in being taken to theatre for surgery by which time his appendix had perforated. He also had concerns about the handover process when a patient moves wards.

The investigation found a number of failings in Mr S's care. In relation to the ED, the complainant had not been given adequate pain relief promptly as befitted his level of recorded pain. The nursing records were minimal so not providing sufficient evidence of care provided there. Handover communication as not properly evidenced. On the ward overnight, and until Mr S was taken to theatre at lunchtime, inadequate observations and monitoring were performed and recorded. When pain relief was administered it was in oral form even though Mr S was due for theatre when a slot became free. So the majority of Mr S's complaints were **upheld.** The decision not to take Mr S for surgery overnight was in line with national guidance (not being life threatening) and so within the bounds of acceptable clinical practice. Whilst the appendix had perforated histology revealed it to be minimal, with no risk of peritonitis resulting. This aspect of the complaint was **not upheld.**

A number of recommendations were made, all of which the Health Board agreed to implement:

a) an apology to Mr S and redress of £750 for the failings found;
b) A review of the ED arrangements for analgesia and of handover processes – copies of new protocol documents to be provided to the Ombudsman in both instances;
c) a governance review within 3 months of nursing professional standards covering assessments, physiological and pain monitoring, record keeping and onward transmission documents between the ED and other clinical environments. Evidence of that review should be provided to the Ombudsman within 2 months thereafter.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201300813 – Report issued February 2014
Mr B complained about the treatment he received for colon cancer between 2011 and 2012. He believed that this should have been diagnosed earlier than it was, that there were errors in the surgery which he underwent and that he was discharged from hospital prematurely. He also expressed concern about the Health Board's proposal to transfer his care to an alternative hospital following his complaint.

The Ombudsman partly upheld the complaint. She found that the Consultant had not discussed the possibility of a further biopsy with Mr B when an initial biopsy was inconclusive, although she believed it was unlikely that the Consultant would have

advised such a course in any event. She found that Mr B had not been given sufficient information about the procedure and the possible risks, and had therefore not been prepared for the difficulties he had experienced. However, the Ombudsman found that the surgery had been carried out to a reasonable standard, and that there was no evidence that he had not been fit for discharge. Whilst the Ombudsman considered that the suggestion of transferring Mr B's care to another hospital might have been appropriate it could have been handled better.

The Health Board agreed to:

- apologise to Mr B for the failings identified;
- in recognition of the additional distress experienced by Mr B by reason of these failings, make a payment to Mr B in the sum of £750 remind staff of the General Medical Council consent guidance and the importance of keeping records of discussions with patients

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201204082 – Report issued February 2014
Mrs A's complaint concerns the failure by doctors treating her husband to diagnose cancer. Mrs A said that she believed that her husband's cancer had been present in 2010. Mrs A also complained about the delays in the Health Board dealing with her complaint.

The Ombudsman's investigation concluded that Mr A's cancer was present in 2010 and was critical that the diagnosis was missed by those treating him and **upheld** this aspect of Mrs A's complaint.

The Ombudsman concluded that the Health Board's delay in dealing with Mrs A's complaint was unreasonable. She expressed concern that as a consequence, the Health Board's ability to learn lessons from Mrs A's complaint was compromised. The Ombudsman **upheld** Mrs A's complaint.

The Ombudsman recommended that the Health Board:

a) provides a fulsome apology to Mrs A both for the significant clinical failing identified and for the inadequate handling of her complaint. Provides financial redress of £2,000 to Mrs A for the distress caused by the failings identified; and a further £500 to Mrs A in recognition of the shortcomings in complaint handling;

b) ensures that clinicians are reminded of the importance of patient involvement in the management of their care and treatment, and also of the need to perform further biopsies and seek specialist advice in cases where tests have shown conflicting results;

c) as part of a wider learning process this report should be discussed with the members of the UGI MDT involved in Mr A's care, consider the issues raised in this case and the learning points that arise.

d) should discuss the contents of this report at an appropriate consultant forum across the Health Board;

e) should share a copy of this report with the Chairman of the Health Board;

f) should carry out a root cause analysis of the failings in respect of complaint handling identified in this report and provide its findings to this office.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201300754 – Report issued February 2014

Mr W complained about the care and treatment he received in hospital following his Trans-urethral resection of Prostate surgery. He was concerned that his warfarin therapy was not managed appropriately, that the monitoring of his urine output was insufficient and that his discharge was premature.

The Ombudsman upheld his complaints. The Health Board confirmed that the instructions of the anti-coagulation clinic were followed. These were contrary to the instructions of the operating surgeon, which her clinical adviser said should have been followed. She also found that the fluid balance charts were inadequately completed and there was insufficient evidence to make an informed decision on discharge. The Health Board had already accepted during its investigation that its routine procedure for urine monitoring was not followed and that Mr W was prematurely discharged.

The Health Board agreed to implement the following recommendations:

a) reinforce the apology for the failings identified and make a payment of £100 in acknowledgement of the distress of being inappropriately discharged;
b) provide evidence of the random spot checks carried out to ensure compliance with its procedure for urine analysis on removal of catheter;
c) provide evidence of the training it has already organised, together with details of how it proposes to ensure that such training forms part of the ongoing development of all relevant staff;
d) issue a reminder to staff on the Ward of the importance of good record keeping and the need to ensure that fluid balance charts contain all necessary information. This should form part of the training that the Health Board has already organised.
e) carry out a feasibility study into the use of bladder scanners for all urology patients following catheter removal.
f) demonstrate that it has in place an appropriate risk assessment procedure which ensures that urological patients being treated on a general ward are appropriately prioritised for transfer to a specialist urology ward where possible.
g) review the conflicting anti-coagulation regimes recommended by the operating surgeon and the anti-coagulation clinic and, in light of the clinically significant differences between the two approaches, ensure that recognised good practice (with reference to any applicable guidance) is consistently followed by all relevant staff.
h) ensure that it has a procedure in place so that recommendations from the anticoagulation clinic for post-operative care are brought to the attention of the

operating surgeon pre-operatively and where differing approaches arise, the rationale for preferring one over the other is discussed and clearly documented in the patient record.

Betsi Cadwaladr University Health Board – Appointments/admissions/ discharge/transfer procedures
Case reference 201203515 – Report issued January 2014
Mrs X complained that Betsi Cadwaladr University Health Board ("the Health Board") failed to recognise the effect a residential setting would have on her mother, Mrs Z's, needs or take into account the effect of arthritic pain on Mrs Z's mental health. Mrs X also complained that the family were excluded from the original assessment process and that there was a failure to conduct any additional assessments. Finally Mrs X complained that the Health Board had failed to adequately respond to her complaints.

The Ombudsman found that, in view of Mrs Z's condition, it was reasonable to place her in a care home; however, there was no evidence that the effects of Mrs Z's condition were considered when finding a placement. Additionally, Mrs Z's records showed a link between her struggling with her daily tasks and her challenging behaviour, yet those links were not recognised. The Ombudsman also noted that, given their first hand knowledge of her condition, it would have been good practice to include Mrs Z's family in the assessment process, and to have arranged regular reviews. Finally, the Ombudsman found that the Health Board had failed to adequately respond to Mrs X's complaint.

It was recommended that the Health Board:

- apologise to Mrs X for the service failure identified in the report;
- pay Mrs X the sum of £250 in recognition of the time and trouble in bringing her complaint to this office;
- remind the relevant staff that where appropriate, information on the differences between care homes and care homes with nursing should be explained to patients and their families/carers;
- remind the relevant staff that where appropriate, patients and their families/carers should be provided with information on how to request a mental health review and a NHS Continuing Health Care funding review;
- remind the relevant staff that where appropriate, it would be considered good practice to include a patient's family/carer in the assessment process;
- include within its training plan training for the relevant staff on the links between pain and challenging behaviour in patients with dementia.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201300132 – Report issued January 2014
Mr C complained about the standard of care and treatment provided to his mother-in-law, Mrs P, at Ysbyty Gwynedd, Bangor, in October 2011. In particular, he complained that there was a failure to initially identify that Mrs P had fractured her shoulder and broken more than one rib. He complained that there was also a failure to complete a manual handling assessment correctly. Mr C believed that as a result, Mrs P was caused more pain than would otherwise have been the case. Mr C was

also dissatisfied with the way the family's complaint was dealt with by the Health Board.

The Ombudsman found that the fracture of Mrs P's shoulder should have been identified sooner than it was. The radiology report on an X-ray carried out shortly after Mrs P's admission was imprecise and did not make clear that there was a new fracture at the sight of a fracture Mrs P had suffered four years previously. In any event it was not clear that the treating doctors had seen the report. The fracture of Mrs P's shoulder was not identified until a further X-ray was carried out 10 days after her admission to hospital. The Ombudsman also found that the manual handling assessment was incomplete. She concluded that both these failings are likely to have caused Mrs P some additional pain and distress and she upheld these parts of the complaint. The Ombudsman did not uphold the complaint about the failure to diagnose of the rib fractures. The Ombudsman upheld the complaint about the handling of the family's complaint.

The Ombudsman recommended that the Health Board:

1. provide a written apology to Mrs P and her family for the failings identified in this report;
2. pay Mrs P £150 to recognise the additional pain and discomfort she was caused due to the delay in diagnosing the fractured shoulder and the failure to carry out an adequate manual handling assessment;
3. pay Mr C and Miss P £100 each to reflect the time and trouble they were put to in pursuing the complaint due to the failings in the way the matter was handled by the Health Board;
4. provide this office with evidence that it has reviewed the effectiveness of the changes it has made in relation to pain and manual handling assessments.
5. remind its radiologists of the need for clarity in reports where a fracture has occurred at or around the site of a previous fracture.
6. provide this office with evidence that it has implemented National Patient Safety Alert 16 and in particular that it has satisfactory systems in place to ensure that requesting clinical teams are made aware of radiology reports.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201204652 – Report issued January 2014
Mrs A complained about removal of a "wart like growth" under her right big toe carried in Wrexham Maelor Hospital ("the Hospital"). She complained that following surgery she was with diagnosed chronic pain syndrome. Mrs A also complained about the poor care she received from the District Nursing team. Finally, she complained about the Health Board's handling of her complaint.

The Ombudsman's investigation found inadequacies in record keeping and consent process by the Surgeon which the Ombudsman considers did not meet the requirement of the General Medical Council and to that limited extent **upheld** this aspect of Mrs A's complaint.

The Ombudsman learned during the course of the investigation that the Health Board had misplaced Mrs A's medical records. She considered that loss of the

records impeded her ability to fully investigate this aspect of Mrs A's complaint and reach an appropriate finding. The Ombudsman concluded that this caused Mrs A injustice and that the Health Board's failings amount to maladministration of Mrs A's complaint. She also found shortcomings in the Health Board's handling of Mrs A's complaint. Mrs A's complaint was **upheld**.

The Ombudsman recommended that the Health Board:

a) apologise to Mrs A for the shortcomings identified by the investigation and make a payment of £350;
b) consider the points raised in relation to consent and the recording of consultation in the patient's medical records. Consider whether there needs to be a Health Board wide review of its consenting procedure particularly in relation to elective surgical procedures;
c) should review the circumstances of this case and consider any improvements it needs to make to its systems for tracking, filing and locating original medical records in its possession, to ensure that its systems are robust.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201203882 – Report issued January 2014
Mr X complained about the standard of care provided to him in September 2012 when he was admitted to a mental health unit on the Wrexham Maelor Hospital site. He complained that the Health Board was late in responding to his complaint; that he was not, because of a faxing error, provided with medication when he should have been; that a diagnosis of "personality disorder" was made (where his current diagnosis had been of a "schizoaffective disorder"); and that there were other shortcomings in his care related to that admission.

The investigation found that, while the Health Board had delayed before responding to the complaint, it had apologised appropriately for the delay and provided a reason for it. The Health Board acknowledged the faxing error, apologised for it and took reasonable steps to make a recurrence less likely. These two complaints were **not upheld**. On the discharge summary, Mr X was noted as having a "personality disorder" when no diagnostic assessment had been undertaken. This caused Mr X distress and the complaint was therefore **upheld**. The other related complaints were **not upheld.**

It was recommended that the Health Board:

a) apologise to Mr X for recording that he had a "personality disorder" when no diagnostic assessment had been undertaken, and for the distress that this caused him;
b) include an entry in Mr X's records which made it clear that the reference to his having a "personality disorder" was made in error and should be disregarded;
c) make a payment of £150 to Mr X in recognition of the distress he was caused.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201203783 – Report issued November 2013
Ms J complained about the treatment her late mother Mrs P should have been on an intensive care ward and she had to feed Mrs P as nobody helped her. On 16 May

2012, Ms J found Mrs P on her bed cold, Mrs P had asked a nurse for help, who said, “later”. Ms J said later that day a porter returned Mrs P and asked for help to move her from the wheelchair, nurses were not in attendance. On 19 May, a Registrar prescribed salt water and a nebuliser to help Mrs P’s breathing, she was not examined. On 20 May, Ms J said nursing staff washed Mrs P against her wishes and she said Mrs P should have been left alone.

During the night, a “machine” was removed from Mrs P’s room against a nursing Sister’s wishes. On 21 May, at 6.30am Mrs P had difficulty breathing. By 7.30am she had not been seen, Ms J’s sister asked nurses for help. A registrar attended and only asked Mrs P to stick her tongue out. Mrs P died at 8.30am. Ms J said that Mrs P suffered and complained about the poor nursing care.

The Medical Adviser said that Mrs P assessment for intensive care was correct and there had not been any failings in Mrs P’s medical management. The Nursing Adviser said that Mrs P received an appropriate standard of nursing care, and the monitoring of Mrs P’s clinical condition was to a high standard. The Nursing Adviser said there were no documented risk assessments or nursing care planning, but her care had been such there was no detrimental effect to Mrs P’s care.

It was recommended that-

- All patients are risk assessed appropriately and care planned accordingly.

- The doctor who attended be identified and highlight the shortcomings in failing to complete medical notes and all doctors to be reminded of the importance of documenting their visits.

The Health Board has agreed to implement these recommendations.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201202835 – Report issued October 2013
Mrs H complained that her GPs twice referred her for endoscopic examination and the HB described them as inappropriate. She complained her medical records had humiliating comments and she suffered age discrimination. Her GORD[1] was not periodically reviewed and it had not been considered whether she had Radiation Enteritis.[2]

The Adviser said that there was no justification for Mrs H not being examined following her GPs referrals, however, the endoscopy performed in 2013 demonstrated no change to Mrs H’s condition. There was no evidence of humiliating comments or that she suffered age discrimination. The Adviser said that GORD should not be periodically reviewed. The Adviser said that after two unsuccessful attempts to intubate the sigmoid colon, a test should have been considered by an experienced colonoscopist, to confirmed or refute Radiation Enteritis.

Mrs H’s complaint in relation to that there was humiliating comments, discrimination on the grounds of age and her GORD not being periodically reviewed, were not

[1] Gastro Oesophageal reflux disease.
[2] Damage to the lining of the bowels due to radiation therapy.

upheld. Her complaints that she was refused an endoscopy in 2010 and 2012 and she might present with Radiation Enteritis were upheld. It was recommended:

(a) The HB apologised for not performing gastroscopy when referred by her GP.
(b) The final report is shared with those that rejected the GPs request
(c) The HB apologise for not performing another endoscopy after two failures to intubate.

(d) The final report is shared with those who performed the sigmoidoscopy.
(e) The HB undertakes a course to determine whether Mrs H has Radiation Enteritis.
(e) Consultants review their practice of mentioning in medical letters that a patient has complain

Betsi Cadwaladr University Health Board – Clinical treatment outside hospital
Case reference 201202715 – Report issued October 2013
The complaint concerns the Health Board's management of Mrs X's circumstances during her pregnancy and subsequent termination. Mr Y said that a Community Midwife did not deal properly with Mrs X's circumstances and made an inappropriate referral to Social Services on 22 October 2009. Mr Y also complained that the Community Midwife and staff at Glan Clwyd Hospital ignored Mrs X's wishes by making arrangements for her to receive an appointment and procedure at a Tertiary Centre which she did not want. Finally, Mr Y complained that the Health Board failed to properly investigate the complaints made against it.

The Ombudsman noted how sad and distressing the circumstances were for Mrs X and her family. He noted that the Health Board in this context needed to manage a number of complex issues including matters of a highly emotional and sensitive nature. The Ombudsman also noted the context in which there was a lack of continuity of care.

The Ombudsman found that the Community Midwife and wider hospital clinicians acted in what they believed were Mrs X's best interests although he found that there were shortcomings in their approach. He said that it was reasonable for a referral to have been made to a tertiary centre to allow for a full consideration of all the options available to Mrs X.

Taking account of clinical advice, the Ombudsman was of the view that the Community Midwife responded appropriately in referring to Social Services in light of her perception of the circumstances and noted that she had also acted on the advice of her supervisor.

The Ombudsman therefore did not uphold the substantive general complaint however he found that there were significant shortcomings in relation to recording practices and the timeliness of the referral to Social Services. He upheld these specific elements of the complaint.

The Ombudsman also considered the Health Board's complaint response and said that although the Health Board appropriately investigated and responded to what it believed was the nature of the complaint, some of its responses could have been clearer. He was concerned that the Health Board did not recognise any

shortcomings in its approach and said that it was concerning that the Health Board failed to agree to meet with Mr Y despite his request and even after this had been suggested through the Independent Review process. The Ombudsman partially upheld this element of the complaint.

The Ombudsman recommended that the Health Board

- Apologises to Mrs X for the shortcomings identified and provides a redress payment of £500 in respect of these,
- Ensures that where child protection referrals are made to Social Services that these are made in a timely manner and in line with statutory guidance,
- Reviews the adequacy of its record keeping and addresses any deficiencies,
- Ensures that the clinicians receive adequate guidance and training in record keeping.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201202406 – Report issued October 2013
Mrs X complained about the care provided to her mother ("Mrs Y") while she was a patient at the Maelor Hospital, Wrexham ("the Hospital"). Mrs Y was admitted to the Hospital with worsening anaemia, shortness of breath and low blood sugar levels. She had a number of pre-existing medical conditions including glaucoma, rheumatoid arthritis, osteoporosis, hearing loss and she was confined to a wheelchair. Mrs Y became infected with C. difficile[3] during her admission. Sadly, she deteriorated and later died at the Hospital. Mrs X complained about the standard of nursing care, inadequate fluid monitoring, communication issues, the insertion of a nasogastric tube[4] without her mother's consent, issues around her contracting C. difficile at the Hospital and the failure to repair a faulty call buzzer above her bed.

The investigation found that there were shortcomings in communication with the family. That aspect of the complaint was **upheld**. No finding could be reached, because of the uncertainty around the issue, in relation to the complaint that a nasogastric tube had been inserted against Mrs Y's wishes. The investigation found that the issue of the faulty call buzzer had been reasonably addressed through the complaints process. That aspect of the complaint was therefore **not upheld**. The other aspects of the complaint relating to C. difficile, fluid monitoring and the standard of nursing care were **not upheld**.

It was recommended that the Health Board should:
(a) Apologise to Mrs X for the shortcomings in communication with the family.

May 2013 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board
The complaint concerned care which Mrs B received while an inpatient at Glan Clwyd Hospital. Mrs B had recently received chemotherapy and radiotherapy for lung cancer in hospitals in England, and was visiting the area when her condition

[3] Clostridium difficile – a bacterium which can cause severe diarrhoea and other intestinal disease.
[4] A tube passed through the nose, throat and into the stomach.

deteriorated. Ms A, Mrs B's daughter, said that staff had not ensured Mrs B had adequate nutrition and fluids, and that failings in care meant that Mrs B had sustained two falls; she also complained about the level of communication with the family, and about errors in arrangements for the transfer of Mrs B which resulted in her being taken to the incorrect hospital.

The Ombudsman partly upheld the complaint. He found that Mrs B received adequate fluids during her stay in hospital, but that the lack of food charts and other documentation meant that he could not be satisfied that this was the case with regard to nutrition. He concluded that Mrs B should not have been left alone in a toilet cubicle due to her previous confusion, and that she should not have had bed rails in place; these two failings led to Mrs B's falls. The Health Board accepted that there had been failings in its communication with Mrs B's family. The Ombudsman was critical of the errors in the records which led to the ambulance service being told to take Mrs B to the wrong hospital, and for the failure to check the destination before Mrs B left. Although, sadly, Mrs B died the following day, the Ombudsman could not say that the extra time spent on the journey was detrimental to her health. He also identified that there had been no "medicines reconciliation" on Mrs B's admission to hospital, resulting in her not being prescribed all the medication she was taking in the community; however, there was no evidence that this caused her any harm.

The Ombudsman recommended:

(a) An apology to Mrs B's family;
(b) Payment of £1500 in recognition of the distress caused by the failings and for their time and trouble in pursuing this complaint;
(c) That staff be reminded of the importance of the "medicines reconciliation" process, and that an audit of this process be carried out on the acute medical ward.

The Health Board accepted the recommendations, and had already put in place an action plan to address the failings.

Case reference 201301299

Not Upheld

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201302229 – Report issued March 2014
Miss A complained about complications from a spinal block which was performed for the caesarean section delivery of her baby. Miss A developed breathing difficulties and needed a general anaesthetic. Miss A also complained about administrative errors which led to notes of a meeting being addressed to her at a non-existent address, and being sent to her former GP.

The Ombudsman did not uphold the complaint. She found that the spinal block had been administered correctly and that the anaesthetist had treated Miss A's breathing difficulties appropriately before deciding to administer a general anaesthetic. The Health Board had already accepted and apologised for the errors in the distribution of the minutes of the meeting.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201205142 – Report issued February 2014
Miss C complained about the treatment she received for a wrist injury sustained in a fall. She was also concerned about an entry in her medical records which she believed contained an unjustified suggestion that she is mentally ill.

Miss C had longstanding problems with her joints, and had been diagnosed with hypermobility syndrome (a condition where joints are noticeably loose and flexible and may dislocate easily). The Ombudsman found that she had received appropriate treatment for her injury, that the entry made in her records many years ago was reasonable and that, in any event, it had not adversely influenced her treatment. The Ombudsman did not agree with Miss C's interpretation of a more recent entry in her records, and considered that the record which was made would be likely to be to Miss C's benefit. The Ombudsman did not uphold the complaint.

GP in Betsi Cadwaladr University Health Board area & Betsi Cadwaladr University Health Board – Clinical treatment outside hospital
Case reference 201300387 & 201300391 – Report issued January 2014
Mrs C complained that her late husband, Mr C, was seen by Dr A on 20 April and Dr B on 18 May 2012 with symptoms of chest pain but that the recurrence of his lymphoma was not diagnosed. Mrs C complained that the GPs did not take further action which she said resulted in missed opportunities to make an earlier diagnosis.

Having obtained professional advice, the Ombudsman **did not uphold** the complaint. The Ombudsman found that the care and treatment provided to Mr C during his consultations was reasonable. In particular, the examination, history and diagnosis reached were appropriate based on Mr C's presenting symptoms and known history at the time. The Ombudsman concluded that the GPs could not reasonably have been expected to have taken any further action during the consultations which could have resulted in an earlier diagnosis of Mr C's recurring lymphoma.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201203692 – Report issued January 2014
Mrs A complained about the care and treatment her husband received when he attended the A&E Department at Ysbyty Glan Clwyd ("the Hospital") in 2009. In

particular she complained that not carrying out a head scan failed to diagnose her husband's subdural haematoma. Mrs A said that her husband should have been prescribed antibiotics to prevent cellulitis. Mrs A further complained that her husband's transfer to the Community Hospital following his surgery was untimely as he was too ill and needed specialist care. Mrs A noted that due to the poor care her husband received he contracted MRSA and Clostridium difficile infections. She was also of the view that not enough was done to keep her husband alive prior to his sad death. Finally, Mrs A said that whilst trying to air these concerns she found it difficult to speak to the relevant consultant as staff were "obstructive".

The Ombudsman's investigation found that the clinical care that Mr A received was reasonable and acceptable within the bounds of clinical practice and therefore did **not uphold** Mrs A's complaint.

In relation to Mrs A's concerns about poor communication the Ombudsman noted that the Health Board had addressed this aspect of Mrs A's complaint and had apologised to her. The Ombudsman noted that there were numerous documented discussions noted with Mrs A and her husband. The Ombudsman did not consider that further investigation would achieve anything further or result in a different outcome.

The Ombudsman suggested that, if it had not already done so, the Health Board should consider the following:

a) introducing an end of life care pathway/palliative care for dying patients and thereafter considering whether refresher training on end of life care pathways for relevant staff is necessary;
b) demonstrate clear pathways of communication between the patients their relatives and the appropriate clinician.

Betsi Cadwaladr University Health Board –
Appointments/admissions/discharge/ transfer procedures
Case reference 201205011 – Report issued December 2013

Mr A complained about delays experienced with his Consultant appointments at the Endcocrine clinic at Ysbyty Glan Clwyd. Mr A has a medical a condition which requires regular monitoring and control of his testosterone levels.

The investigation found that Mr A had experienced three periods of delay since his initial referral to the clinic in 2011. During these periods it was necessary for him to contact the clinic himself to make enquiries about the delays. At this point he was advised that the service was experiencing difficulties. The Health Board acknowledged that it had experienced delays with the clinic in consequence of the significant increase in referrals to it. It said that many patients were advised of the delays during their clinic appointments and were being taken into account by the clinicians when planning review appointments.

Whilst, the Health Board may have adopted this approach with some patients, this did not occur in Mr A's case. It would appear that his expectations were raised during each review that he would be seen again in accordance with the timescale indicated by the Consultant. The Ombudsman was satisfied that there was a lack of communication relating to the difficulties faced by the service. The Ombudsman was

pleased to note that Mr A's most recent review was undertaken within the anticipated timescale and that the Health Board is continuing to develop the service to reduce the current waiting times.

The Ombudsman **recommended** that within one month of the date of this report, the Health Board should:

(a) Apologise to Mr A in respect of the periods of delay and in respect of its failure to provide him with information about the delays in a more timely and effective manner.

(b) The Health Board was also asked to reflect on points of service improvement highlighted in report.

April 2013 – Patient list issues – Betsi Cadwaladr University Health Board
In September 2012, Ms J complained to the Ombudsman. She had been on the orthopaedic waiting list since 2 June 2011. She said she had been told she would have surgery on her shoulder on 24 February 2012. On 16 February, she attended a pre-operative appointment. She said the Consultant failed to examine her properly, cancelled the surgery and instead referred her for additional physiotherapy. She said the surgery was cancelled because she declined a "short-notice" appointment for the operation to take place on 17 February. She said she then obtained a second opinion, a scan and X-rays, which she funded privately. Ms J said that as a result of the situation she had to wait for surgery and endure further pain. She said the NHS should reimburse the private costs involved and the LHB should review the procedures for examining patients before surgery.

My investigation considered evidence from Ms J, the LHB and Ms J's GP. I also obtained advice from an experienced Consultant Orthopaedic Surgeon ("the Adviser"). The Adviser reviewed Ms J's medical records, the X-rays and scans. He said treatment of shoulder pain involves a range of options, only one of which is surgery. He also said the examination on 16 February was appropriate and the Consultant's decision to recommend further physiotherapy was reasonable.

My investigation did not find any evidence of a failing in the care given to Ms J. Therefore, I did not uphold the complaint and I concluded that the LHB should not be required to reimburse the cost of the private consultation, scan and X-rays.
Case reference 201200465

Quick fixes and Voluntary settlements

Betsi Cadwaladr University Health Board – Continuing care
Case reference 201304728 – March 2014
Mr J complained about an independent review panel's consideration of his request for a review of a decision that his mother, Mrs J, was not eligible for NHS funded continuing care.

After being approached by the Ombudsman, the Health Board offered to settle the case by convening another Independent Review Panel to consider the matter afresh. The Ombudsman discontinued the investigation on the basis that this was a suitable resolution of Mr J's complaint.

Betsi Cadwaladr University Health Board & Powys Teaching Health Board – Continuing care
Case reference 201303838 & 201304743 – January 2014
Mr A's solicitors complained on his behalf about the refusal to reimburse care home fees for the late Mrs B. Mrs B was assessed as being eligible for NHS Funded Continuing Care from 1 November 1997 to 30 October 1998 and from 22 December 1999 to 10 January 2000. The refusal to reimburse the fees for the entire eligibility period was on the basis that the proofs of payment were insufficient. Mr A's solicitors said that the request for further proofs of payment was unreasonable as, due to the passage of time, none existed.

After the Ombudsman commenced the investigations, Betsi Cadwaladr University Health Board made an offer of payment to Mr A. This was accepted by Mr A.

Betsi Cadwaladr University Health Board – Complaints Handling
Case reference 201305087 – January 2014
Mr X complained that the Health Board failed to respond in full to his original complaint and disregarded his subsequent e-mails and phone calls.

Following contact from the Ombudsman's office, the Health Board agreed to contact Mr X to offer a meeting to discuss the outstanding concerns.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201303941 – November 2013
Mr X's complaint related to concerns he had regarding the treatment of his father, Mr Y, whilst a patient at Ysbyty Gwynedd. Since making his original complaint to the Health Board, Mr X had not received the final response. The Ombudsman's office contacted the Health Board, which agreed to send Mr X its final response by an agreed date.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201303935 – November 2013
Mrs W complained that after my referral to the Health Board on 4 July 2013, Mrs W had only received one letter from it stating that the investigation was still ongoing and that it would contact Mrs W in due course. To date Mrs W has not received any other correspondence.

Upon receiving Mrs W's complaint, the Ombudsman contacted the Health Board and asked for further information, which it has provided to me today. Mrs W's response is awaiting final approval and the Health Board has agreed that Mrs W's response will be sent to her by the end of next week, Friday 15 November 2013. The Ombudsman also asked the Health Board to include an apology for the length of time it has taken to respond to Mrs W.

Betsi Cadwaladr University Health Board – Continuing care
Case reference 201303322 – October 2013
Mr R (who lived in England but whose GP was based in Wales) complained that a referral his GP had made to the Health Board's Mental Health service had been delayed, causing him stress and inconvenience. He also complained about how his complaint had been dealt with.

Enquiries revealed that the referral had not been dealt with as smoothly as it ought to have been, and had been compounded by a reorganisation of the team dealing with referrals from GPs as well as the initial referral of Mr R across the border to England. The Health Board acknowledged that the delay should not have happened, and that its complaint response ought to have been more transparent in explaining this to Mr R. The Health Board agreed to provide a more detailed written explanation to Mr R, and redress of £350 for the stress and inconvenience caused to him.

Betsi Cadwaladr University Health Board – Appointments/admissions/ discharge and transfer procedures
Case reference 201301327 – October 2013
Mrs H complained on behalf of her daughter, Mrs R, about a decision made by Betsi Cadwaladr University Health Board's mental health services to allow Mrs R home on leave while she was detained under section 3 of the Mental Health Act 1983.

The Health Board offered to settle the complaint by commissioning a consultant psychiatrist from outside the Health Board to review the care provided to Mrs R. Mrs H and the Ombudsman felt that this was an appropriate proposal, and the Ombudsman's investigation was discontinued on that basis.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201300164 – October 2013
Mrs B complained about the care that her father, Mr B, received in connection with hip replacement surgery. She said that he waited too long, involving various cancelations, some of which have not been explained properly. Eventually he had successful surgery but at a hospital geographically inconvenient to the family. Mrs B also complained about heart medication that Mr B received whilst awaiting hip surgery.

The Ombudsman came to an initial view that Mr B had suffered unnecessarily due to delays in his surgery and agreed that Mr B and his family had not had suitable explanations. He also had concerns about MRSA screening, communications and planning. However, he found no fault in the matter of the heart medication.

The Health Board recognised that there were shortcomings in its care and offered to settle the matter as follows:

a) apologise to Mr B;
b) pay Mr B £3000 for the injustice he suffered;
c) pay Mrs B £400 for her time and trouble in pursuing the matter;
d) offer to meet Mrs B to discuss outstanding concerns and provide an evidence-based action plan to respond to the issues that it and the Ombudsman had identified during the investigation.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201302475 – October 2013
Mr R complained that, despite submitting a complaint to the Health Board in March 2013 about his treatment during and following arthroscopy surgery on his left hip, he was still waiting for its response at the time he submitted his complaint to this office in July 2013.

The Ombudsman's office made several attempts to obtain an explanation for the delay and, despite attempts to informally resolve the complaint by asking the Health Board to provide a response, this information / resolution was not forthcoming. An investigation was therefore commenced. The Health Board subsequently contacted this office with an explanation of the action it had already taken to deal with the complaint, prior to the start of our investigation, which was disappointingly not conveyed to this office when the opportunity to do so was presented. On the basis of the action being proposed, which would address Mr R's complaint, it was decided that this was reasonable and the matter was settled on this basis.

September 2013 – Complaint-handling – Betsi Cadwaladr University Health Board
Mrs M complained that she made a complaint to the Health Board in March 2012 but had yet to receive a final response from the Health Board. Following contact from the Ombudsman's office, the Health Board advised that it had closed the complaint in March 2012. The Health Board advised that, due to an administrative error, it had failed to inform Mrs M that it had closed the complaint. At the time, it had been considered more appropriate to consider the complaint through its disciplinary procedures rather than a concerns complaint and therefore the case had been closed.

The Health Board agreed to contact Mrs M to apologise for this error and to explain to her what action it had taken in relation to the concerns that she had raised.
Case reference 201300256