Our ref: PT/jm
Ask for: James Merrifield
Your ref:
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Date: 9 July 2013
James.Merrifield@ombudsman-wales.org.uk

Ms Allison Williams
Chief Executive
Cwm Taf Local Health Board
Dewi Sant Hospital
Albert Road
Pontypridd
Rhondda Cynon Taff
CF37 1LB

Dear Allison

Annual Letter 2012-2013

Following the recent publication of my Annual Report, I am pleased to provide you with the Annual Letter (2012-2013) for Cwm Taf Health Board.

As outlined in my Annual Report, the number of new complaints to my office increased by 12% compared with 2011/12. Health complaints continue to be the most numerous type of complaint and now account for more than a third of all complaints received. Whilst some of the increase can be attributed to changes brought about under the Putting Things Right redress arrangements, the increase almost certainly reflects a greater dissatisfaction with the health service.

In reference to the overall performance of Health Boards in Wales, there has been a 35% increase in the number of investigation reports issued by my office during 2012/13 compared with 2011/12. I have also again had cause to issue a number of Public Interest Reports identifying serious concerns and failings, all of which have concerned health bodies. Whilst the average number of 'not upheld' reports issued against health bodies has remained the same as last year, I am disappointed to note such a large increase in the average number of 'upheld' reports from 11 to 21 reports.

It is worth noting a further year-on-year increase in the levels of 'Quick Fixes' and 'Voluntary Settlements' achieved by this office, from 13 to 16 cases. In order to maximise the opportunities to learn lessons from these types of cases, you can now find the summaries of quick fixes and voluntary settlements included in my quarterly publication, The Ombudsman's Casebook.

However, I am disappointed to note that the amount of time taken by public bodies in Wales in responding to requests for information from my office has not improved. I am concerned that 45% of all responses took longer than five weeks, with 28% of responses taking in excess of 6 weeks. Whilst I appreciate that resources are stretched at this time, such delays obstruct me from providing complainants with the level of service which they should rightly expect to receive and I urge all Welsh public bodies to review their performance.

In reference to your Health Board, there have been increases in the number of complaints received and investigated by my office, which are both also in excess of the average. Whilst the largest area of complaint is 'clinical treatment in hospital', the number of complaints is below the health body average for the second consecutive year. However, the number of 'upheld' reports issued by my office in relation to your Health Board is above the average; it has also been necessary to my office to issue two Public Interest Reports. It is disappointing to note that more than half of your Health Board's responses to requests for information from my office took longer than five weeks.

As with previous exercises, I have copied this correspondence to the Chair of your Health Board with the intention that it be considered by the Board. I would also welcome the opportunity to meet and my office will be in contact shortly to make the necessary arrangements. Finally, a copy of this letter will be published on my website.

Yours sincerely

Peter Tyndall
Ombudsman

Copy: Chair, Cwm Taf Health Board

Appendix

Explanatory Notes

Section A compares the number of complaints against the Health Board which were received by my office in 2012-2013 with the average for health bodies (adjusted for population distribution[1]) 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 2012-2013, 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 2012-2013.

Section E compares the number of complaints against the Health Board which were taken into investigation by my office in 2012-2013, with the average for health bodies (adjusted for population distribution) during the same period.

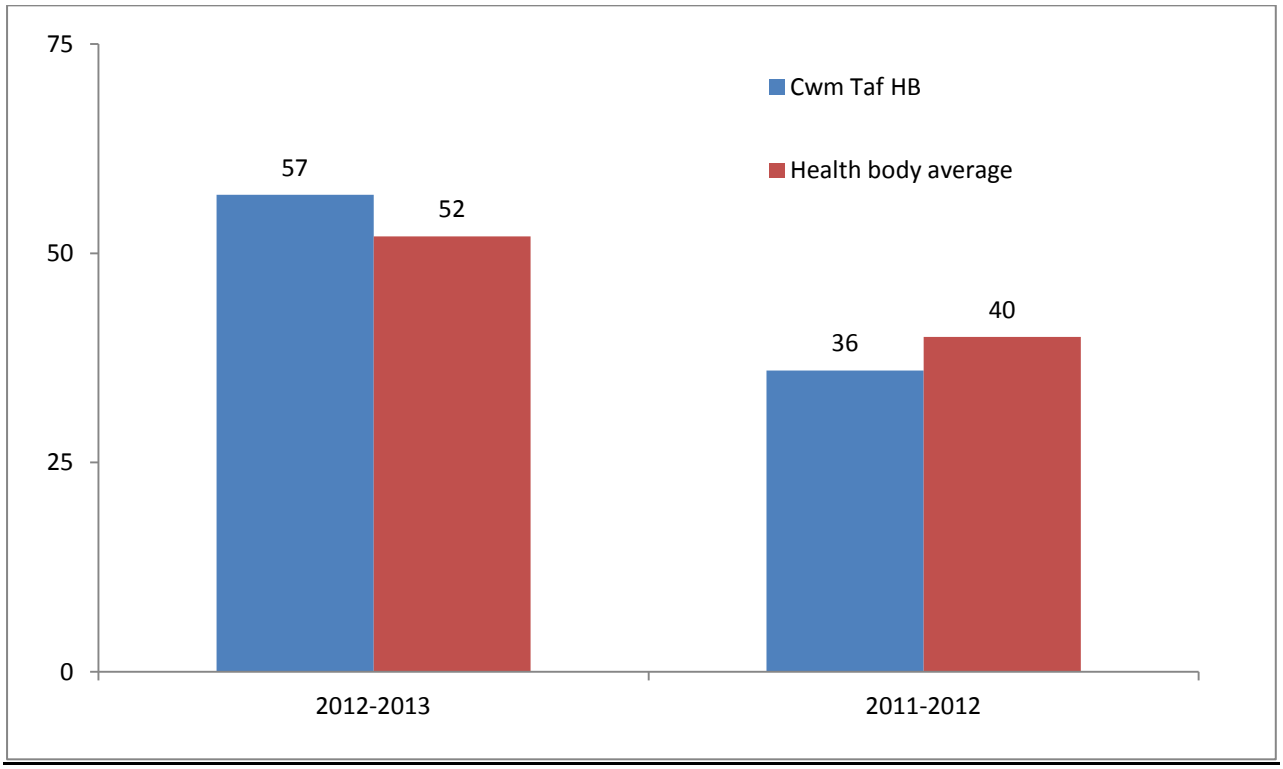
Section F compares the complaint outcomes for the Health Board during 2012-2013, with the average outcome for health bodies during the same period. Public Interest reports issued under section 16 of the Public Services Ombudsman (Wales) Act 2005 are recorded as 'Section 16'.

Section G compares the Health Board's response times during 2012-2013, 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 2012-2013.

[1] http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-262039

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

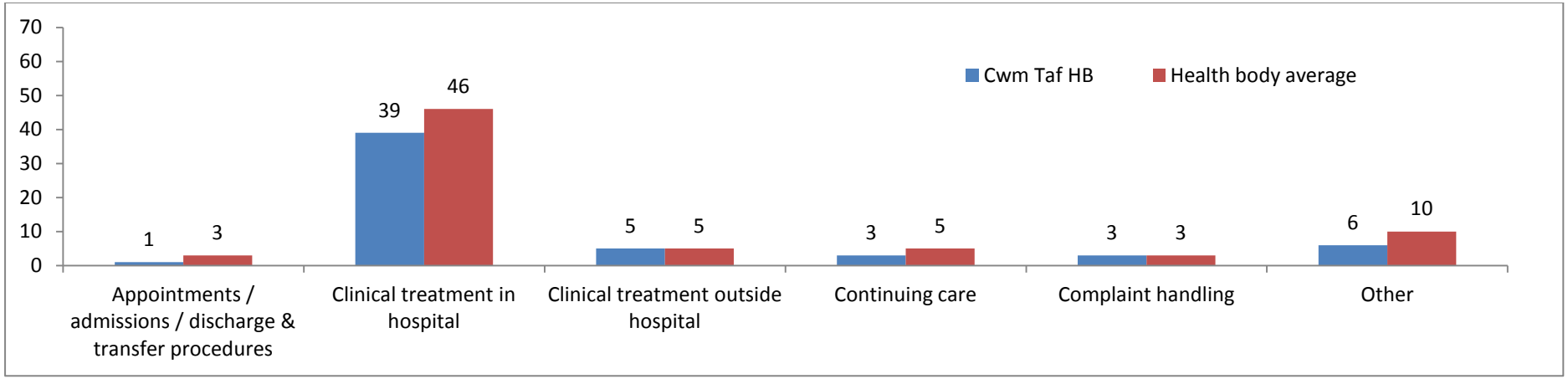


B: Complaints received by my office

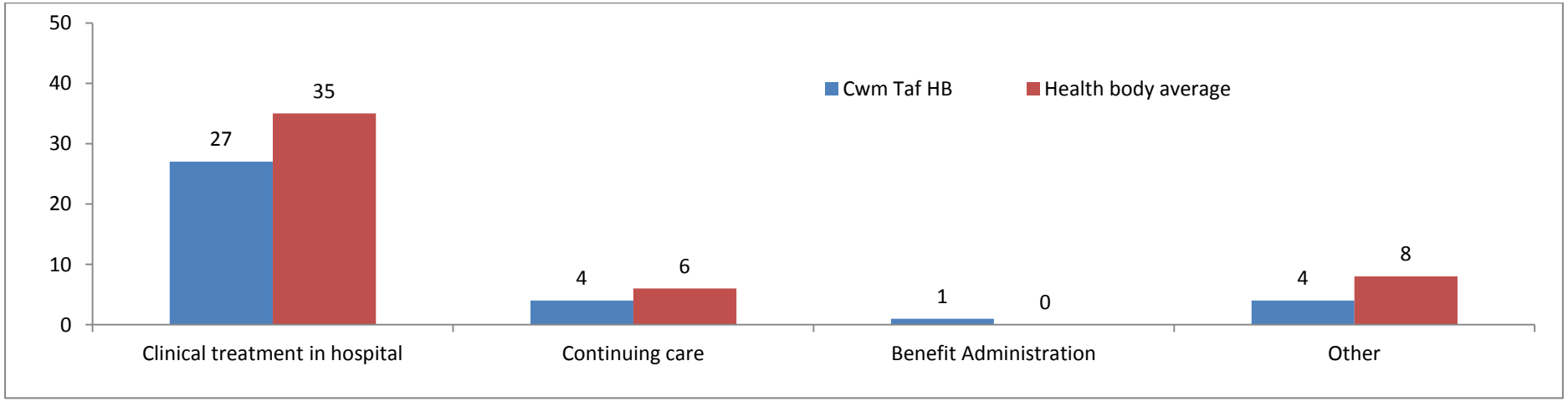
Subject	2012-2013	2011-2012
Appointments/ Admissions/ Discharge and transfer procedures	1	0
Clinical treatment in hospital	39	27
Clinical treatment outside hospital	5	0
Continuing care	3	4
Complaint-handling	3	0
Benefits Administration	0	1
Other	6	4
TOTAL	**57**	**36**

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

2012-2013



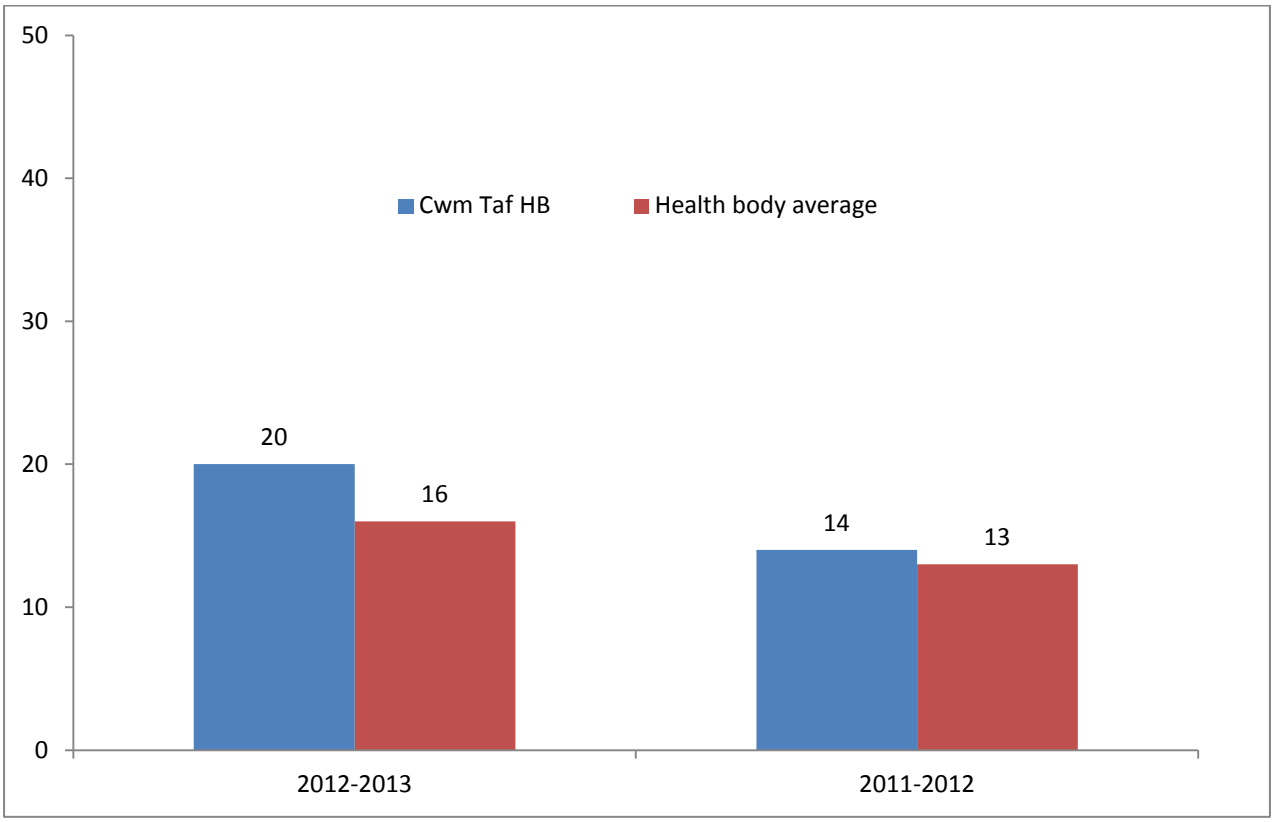
2011-2012



D: Complaints taken into investigation by my office

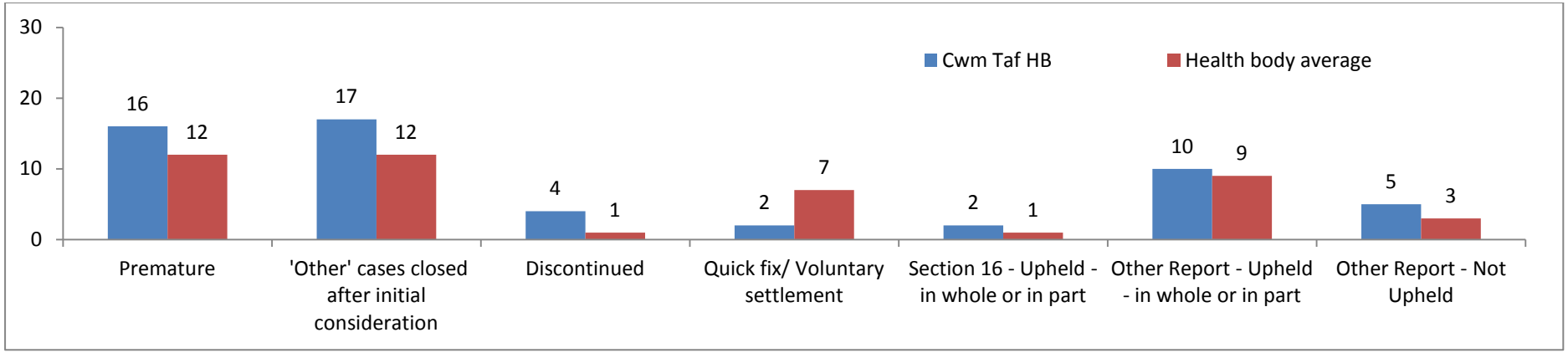
	2012-2013	2011-2012
Number of complaints taken into investigation	20	14

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

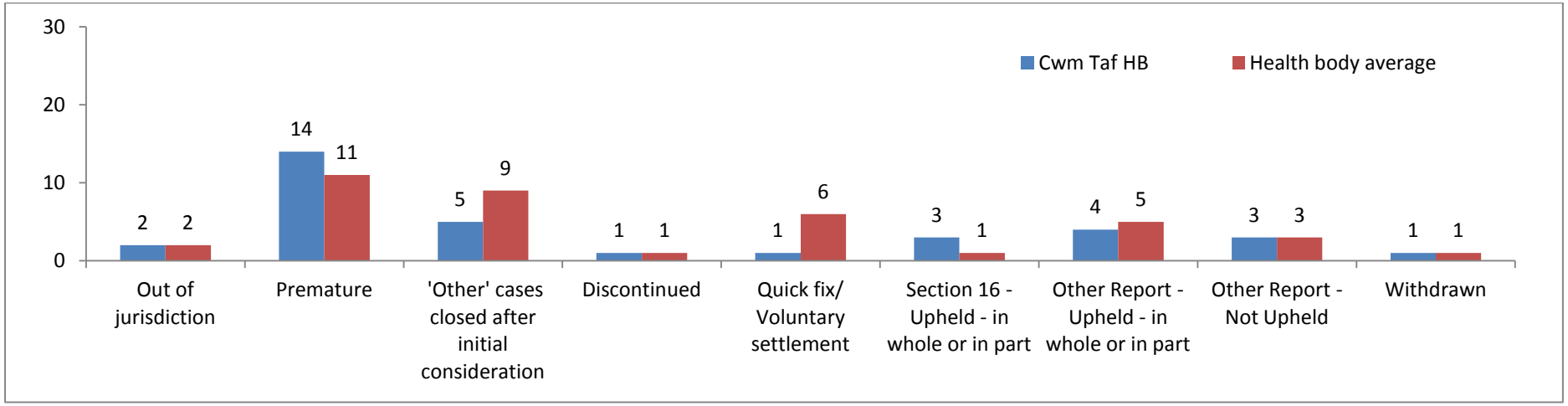


F: Comparison of complaint outcomes with average outcomes for health bodies, adjusted for population distribution

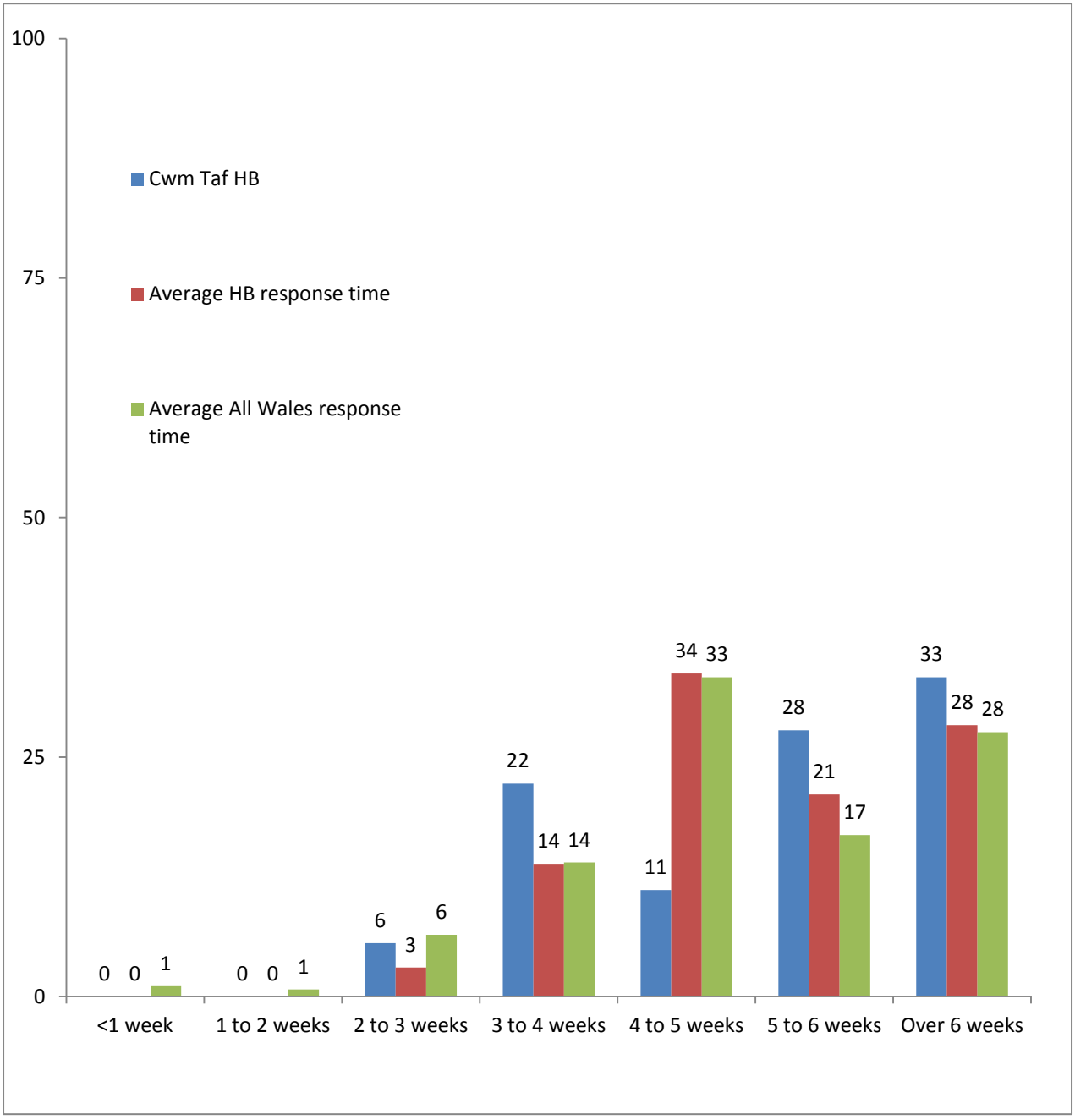
2012-2013



2011-2012



G: Comparison of Health Board times for responding to requests for information with average for health bodies and All Wales response times, 2012-2013 (%)



H: Report summaries

Public Interest Reports

December 2012 – Clinical treatment in hospital – Cwm Taf Health Board
Mrs B complained about Cwm Taf Health Board ("the Health Board") in relation to treatment she received at Prince Charles Hospital in July 2011. Mrs B explained that she fell into a pond and sustained a broken ankle. She said that the Hospital should have transferred her urgently to a specialist centre due to the circumstances and severity of the fracture. She added that the treatment she received at the Hospital was inappropriate and led to her having to have an amputation of her lower leg after she was belatedly transferred.

The Ombudsman concluded that an immediate transfer was not necessary. However, he found that due to the possibility of marine type infection, the Hospital should have taken urgent microbiological advice. He found that once the wound was infected, an urgent transfer to a specialist centre should have occurred. The Ombudsman also had concerns about the supervision of the junior surgeons who operated on Mrs B's ankle.

The Ombudsman recommended that the Health Board pay Mrs B £3000 as an acknowledgement of the injustice she suffered because of the Health Board's failings. He also made a variety of systemic recommendations including de-briefing activities, record keeping and supervision of junior surgeons. The Health Board accepted his recommendations.
Case reference 201200624

November 2012 – Clinical treatment in hospital – Cwm Taf Health Board
Mrs J, the daughter of the late Mrs Y, complained to Cwm Taf Health Board about the clinical investigations and treatment provided to her mother when she attended the Accident & Emergency Department on 13 May, and the Medical Day Unit at Royal Glamorgan Hospital on 14 May 2010. Sadly, Mrs Y died following her discharge on 16 May 2010. Pulmonary thromboembolism was recorded as the principal cause of death.

Mrs J complained that the clinicians treating her mother failed to take timely and appropriate action in response to a blood test result which indicated thrombosis. Mrs J considers that had prompt action been taken when the result was available on 14 May 2010, her mother's death may have been prevented.

The Ombudsman's investigation found that the test was viewed by a nurse before Mrs Y's discharge on 14 May. Mrs Y's blood result was positive. A positive result can indicate thrombosis. The test result does not appear to have been appropriately considered, if at all, by the doctor who made the decision to discharge Mrs Y or by the Consultant with overall responsibility for her care before her discharge.

The Ombudsman concluded that the failure to consider and act upon the positive blood test result before making the decision to send Mrs Y home fell below an acceptable standard of care. This failing gave rise to a missed opportunity to make the correct diagnosis and to treat Mrs Y appropriately. The treatment that should

have been given might have prevented her death. The investigation also identified a number of additional failings on the part of the Health Board.
The Ombudsman upheld the complaint and recommended that the Health Board should provide explanations and an apology to Mrs J and her family in addition to a redress payment of £ 5,000.

Case reference 201101484

Other reports – Upheld

March 2013 – Clinical treatment outside hospital – Cwm Taf Health Board
Mrs Y complained about the care and treatment that her late husband Mr Y received from Cwm Taf Local Health Board. Mrs Y said that there was a failure to monitor and assess the level of deterioration in Mr Y's heart condition despite him having advised clinicians of his shortness of breath and palpitations. Mrs Y also expressed concern that up to date investigations had not been carried out and that there had been a failure to provide outpatient appointments to Mr Y for a period during 2010/11.

Taking account of clinical advice the Ombudsman was of the view that Mr Y had received appropriate treatment for his condition of intermittent atrial fibrillation. The Ombudsman noted that previous cardiac investigations (echocardiogram, 24-hour heart rhythm monitor, exercise tolerance test and various ECG recordings) showed nothing to suggest underlying coronary disease. The Ombudsman also found that in the absence of evidence of ongoing cardiac symptoms such as exertional chest pain or worsening palpitations that there was no clinical indication to investigate for underlying coronary heart disease.
Mrs Y raised particular concerns about her late husband's appointment with the Consultant Cardiologist on 10 May 2011. The Ombudsman found that the clinical review performed by this Consultant was documented to have revealed normal findings with no clinical features of overt heart failure. The Ombudsman said that in the absence of symptoms of exertional chest pain (angina) and in the absence of a previous history of myocardial infarction, further tests would not have been indicated at this point either.

Mrs Y also raised concerns about a prescription of Cialis medication. She was concerned about whether Mr Y should have taken these tablets and whether he suffered side effects from them. The Ombudsman found that it was impossible to say whether or not this medication contributed to Mr Y's sad death. However he found that Mr Y had been properly assessed and prescribed this drug and that the main cardiac contraindications for Cialis tablets were not found to have affected Mr Y at that time.

The Ombudsman did not uphold the complaint that there was a failure to monitor, assess and carry out up to date investigations of Mr Y's condition. The Ombudsman did express concern about the number of Mr Y's cardiology outpatient appointments being cancelled during 2010/11 and upheld this particular element of the complaint. However, taking account of the clinical advice he received the Ombudsman did not consider that the unsatisfactory arrangements had any significant bearing on the management of Mr Y's clinical condition and his subsequent sad death.

The Ombudsman recommended that the Health Board should apologise for the inconvenience of the cancelled appointments and the unnecessary concern these caused to Mrs Y and recommended that the Health Board reviewed the number of cardiology outpatient appointments which have been cancelled and ensure that action is taken to address any deficiencies.
Case reference 201201587

February 2013 – Clinical treatment in hospital – Cwm Taf Health Board

Mr A complained about the standard of care and treatment provided to his brother-in-law, Mr B, by Cwm Taf Health Board's mental health services in 2011. Mr B was being treated in the community for depression before being admitted to hospital as an informal patient after an attempt to take his own life. Mr B subsequently absconded from the hospital and has not been seen or heard from since.

The Ombudsman found that Mr B's treatment in the community was of an acceptable standard, albeit his parents should have been offered a carers' assessment. The Ombudsman considered that the team treating Mr B acted appropriately to arrange an informal admission after the attempt on his life and after new information became available.

The Ombudsman found that the standard of care Mr B received in hospital was broadly reasonable, and there was some evidence of good practice. However, he did identify some failings in relation to record-keeping, the lack of clarity around Mr B's leave arrangements, and the fact that Mr B was able to leave the ward unnoticed despite being subject to enhanced observations. He therefore partly upheld the complaint to the extent of the failings identified.

The Ombudsman recommended that Mr B's family be provided with a formal apology for the failings identified. He made further recommendations relating to the standard of record-keeping, leave arrangements and the quality of engagement and observation on the ward for patients who are subject to enhanced observations. The Health Board accepted the recommendations.

Case reference 201200350

November 2012 – Clinical treatment in hospital – Cwm Taf Health Board

Mrs A complained about the inpatient care provided for her father, Mr B, by the Health Board. She indicated that its response to his needs in respect of nutrition, toileting, medication and clothing had been lacking. She suggested that its arrangements for the removal of used urine bottles were inadequate. She alleged that Mr B's nurse call button had been broken for two days. She reported that staff members had also hidden a working call button from him. She said that the Health Board had given her incorrect information about his MRSA status. She contended that he had contracted MRSA in hospital. She indicated that she was dissatisfied with the Health Board's response to his positive MRSA specimen result. She suggested that the Health Board's communication with her, about Mr B, had been poor.

The Ombudsman upheld the nurse call button and medication parts of Mrs A's complaint. He partly upheld the urine bottle and MRSA elements of it. He did not uphold its nutritional, toileting, communication and clothing aspects. He recommended that the Health Board should remind staff members that call buttons should be within easy reach of patients at all times. He asked it to give Mrs A more information about how it tries to ensure that this is the case. He recommended that it should apologise to Mrs A, in writing, for incorrectly informing her that it had identified MRSA in relation to Mr B. He also asked it to apologise to Mrs A for failing to tell her of his earlier MRSA status. He recommended that the Health Board should remind staff members that patients, who have positive MRSA specimen results, should have MRSA body screens and that their carers should normally be informed of their MRSA status. The Health Board agreed to comply with all of these recommendations.

Case reference 201202031

October 2012 – Clinical treatment in hospital – Cwm Taf Health Board
Mrs T complained to the Ombudsman about the treatment her late father (Mr T) received at the Royal Glamorgan Hospital in August 2010. Her concerns included a failure to provide a nasogastric tube (NGT) in a timely manner in order to provide him with nutrition and appropriate medication; the unavailability of medical staff over a weekend; difficulties communicating with the ward and questions about appropriate assessments. Sadly Mr T died some five days after admission.

Some elements of the complaint were upheld. These included a failure to insert the NGT in a timely manner; failure to provide nutrition over the weekend in question whilst Mr T was nil by mouth; the lack of review over the weekend and communication difficulties. Recommendations were made about reviewing guidelines relating to NGTs and auditing the intervals taken to insert them. It was recommendations that the Health Board considered changes in relation to visiting hours on the ward and ensuring improved communication. Redress of £500 and an apology were recommended. No recommendations were made in relation to reviewing patients over weekends because it was considered that recommendations issued as a result of a previous report addressed these concerns.

Case reference 201102383

September 2012 – Clinical treatment in hospital – Cwm Taf Health Board
The complainant was unhappy with his late father's treatment for lung cancer at the Royal Glamorgan Hospital. He said that there had been a delay in diagnosis and his father (Mr Y) had been sent home initially from Accident and Emergency ('A and E'). He maintained that family members had difficulties in coming to terms with his father's sudden death because doctors had not advised them that he had lung cancer.

The Ombudsman, having taken independent medical advice, found that there were some shortcomings when Mr Y first presented at A and E and that he probably should have been admitted. Also abnormalities on a chest X- ray were not followed up as they should have been. He concluded, however, that this had no significant effect on the outcome because Mr Y was admitted a few weeks later. But had investigations started sooner the family might have had some weeks longer to come to terms with Mr Y's diagnosis. The Ombudsman was satisfied that the medical records confirmed that the family had been told that test results were suspicious and did not uphold the complaint that there were shortcomings in communication.

Case reference 201102404

August 2012 – Clinical treatment in hospital – Cwm Taf Health Board
Mr F complained about the standard of orthopaedic care provided to his late mother, Mrs F, after she fractured her hip. Mrs F had Felty's syndrome which meant that she was at an increased risk of infection. Mr F complained that the orthopaedic consultant had not fully considered all treatment options for her (in particular, non-surgical management of the fracture). He also complained that clinical staff had not recognised that the surgical wound had become infected until it was too late. Sadly Mrs F died of sepsis several weeks later.

The Ombudsman sought clinical advice on the complaint. He found no failings in the clinical care provided to Mrs F as non-surgical management was not appropriate in her case. He also found the monitoring of her condition and the instigation of antibiotic treatment were reasonable. For these reasons, the Ombudsman did not uphold the complaint about the clinical care. On a general point, the adviser highlighted the importance of the input of an orthogeriatrician both pre- and post-operatively in elderly hip fracture patients. In addition, he stated the importance of striving to reduce infection rates following surgery. The only truly acceptable infection rate should be 0%, even if this may prove unobtainable.

The Ombudsman upheld Mr F's complaint about the manner in which his complaint was handled by the Health Board. The Health Board failed to arrange a meeting between Mrs F's family and the clinicians involved for over six months. This was clearly unacceptable.

Case reference 201101978

June 2012 – Clinical treatment in hospital – Cwm Taf Health Board

Mrs A complained about her treatment and care at the Royal Glamorgan Hospital during her pregnancy. Mrs A said that she was not provided with counselling before she consented to an irreversible sterilisation procedure carried out when her baby was delivered by caesarean section. Mrs A said that, if she had received the appropriate counselling, she would not have gone ahead with the sterilisation. This was a decision that she deeply regretted.

The Ombudsman found that, whilst there was some evidence of counselling having been given to Mrs A, the Health Board had failed to follow professional guidelines on male and female sterilisation setting out the approach that should be taken to counselling and consent. The risks relating to the sterilisation were also not properly identified on the consent form that Mrs A signed agreeing to the procedure. The Ombudsman was unable to conclude that, but for the appropriate counselling or consent, Mrs A would have decided against the procedure.

The Health Board agreed to apologise to Mrs A and to pay her the sum of £500 in recognition of the failings identified and for her time and trouble in pursuing the complaint. The Ombudsman also made a number of recommendations, including the introduction of written information for patients on sterilisation, to improve the Health Board's practice in this area.

Case reference 201100539

May 2012 – Clinical treatment in hospital – Cwm Taf Health Board

Mr A complained about Cwm Taf Health Board ("the HB") in relation to the care of his father, Mr B. Mr A said that Mr B attended A & E in January 2010. He was sent home, despite suffering from severe abdominal pain that required morphine. Mr A explained that sadly his father was found dead at home hours later. He said that, despite the HB accepting that it was an error not to admit Mr B, he considered that the outcome might have been different had that happened. Mr A did not accept that the HB's explanation was adequate or that its re-assurances that Mr B would have died in any case were necessarily correct.

The Ombudsman upheld Mr A's complaint. He found that doctors had made a significant error sending Mr B home in the context of his symptoms and other factors. He also concluded that the HB had not fully investigated the underlying reasons for the error or fully acknowledged the additional trauma suffered by the family concerning the circumstances in which Mrs B found her husband's body. The Ombudsman said that a combination of error and inadequate communications between a junior and senior doctor in the context of a busy environment led to the decision to send Mr B home. Despite these findings, the Ombudsman concluded that it was likely that Mr B would have died even if he had been admitted. Moreover, there was no indication that Mr B's death was imminent at the time that he attended A & E. The HB agreed to implement the Ombudsman's recommendations. It has offered to pay Mrs B £2000 as an acknowledgement of the additional and unnecessary distress caused, implement some procedural changes and review capacity within the A & E Department.

Case reference 201101000

May 2012 – Appointments/admissions/discharge & transfer procedures – Aneurin Bevan Health Board, Cwm Taf Health Board & Caerphilly County Borough Council

Mrs C complained about aspects of the care and treatment of her severely disabled husband following his admission to Prince Charles Hospital (PCH) in February 2009. PCH is managed by Cwm Taf Health Board. Mr C was transferred to Ystrad Mynach Hospital (YMH) from where he was discharged home in June 2009. YMH is managed by Aneurin Bevan Health Board. Caerphilly Council's social services were also involved in Mr C's care.

The Ombudsman's investigation found that as Mr C's ability to communicate was very limited, his capacity should have been assessed under the Mental Capacity Act 2005 (MCA). Despite Cwm Taf HB and Caerphilly social services being in agreement with the need for this, Cwm Taf HB failed to carry out an assessment. This meant that, at best, Mr C was given very little choice about his care and treatment, and about whether he remained in hospital, and, at worst, he was detained in hospital against his will. This was therefore a significant failing and the complaint was upheld. Cwm Taf and Aneurin Bevan Health Boards agreed with the Ombudsman's recommendation to provide training to staff about their responsibilities under the MCA.

The Ombudsman investigated a number of other complaints. He concluded that it had taken too long to discharge Mr C from hospital, and asked the authorities to consider how the process can be speeded up. He also upheld a complaint that Mr C was allowed to remain constipated for several days. But he did not uphold complaints relating to mouth care and provision of antibiotics, or that it was inappropriate to consider the possible need to instigate the Protection of Vulnerable Adults procedure.

Finally, the Ombudsman upheld Mrs C's complaint that the three bodies failed to provide a joint or cohesive response to her complaints.

Case reference 201002841, 201100156 & 201100157

April 2012 – Clinical treatment in hospital – Cwm Taf Health Board

Mr P complained about the standard of care and treatment provided to his late wife, Mrs P, during her admission to the Royal Glamorgan Hospital ("the Hospital"). Mrs P presented at the Hospital in the early hours of 6 June 2010 complaining of severe abdominal pain. Mrs P had a history of cancer and had been diagnosed by a GP the previous evening with a urinary tract infection (UTI). She sadly died on the morning of 7 June. Mr P complained about the care and treatment provided to Mrs P while she was a patient at the A&E department and when she was later transferred to Ward 7, a surgical ward. In particular, Mr P complained that the triage assessment of Mrs P at A&E was inadequate. He complained that pain relief was not administered in a timely manner. Mr P considered that there was an unacceptable delay before Mrs P was seen by a doctor at A&E, having had to wait over three hours to be seen. Mr P was aggrieved that Mrs P did not receive antibiotics in a timely manner. Mr P considered that the overall treatment of Mrs P's condition was inappropriate. Mr P complained that the Health Board's investigation of his concerns had been inadequate and incomplete.

The Ombudsman's investigation found that whilst elements of the triage assessment were undertaken reasonably, others were not. Given her severe abdominal pain, Mrs P should have been given a higher priority. This aspect of the complaint was therefore upheld. The investigation found that there was an approximately three and a half hour delay from when Mrs P was triaged to when she was seen by a doctor and pain relief administered. Pain relief was not provided in a timely manner and there was an unacceptable delay before she was seen by a doctor. These complaints were upheld. In light of the clinical advice provided to me, I could not make a definitive finding on whether antibiotics were clinically required sooner than when they were provided. In view of the uncertainty relating to the antibiotic treatment, I could not make a definitive finding on whether overall treatment provided to Mrs P had been inappropriate. The investigation found that the Health Board's investigation of Mr P's concerns had not been inadequate. This aspect of the complaint was not upheld. It was recommended that the Health Board take steps to address the shortcomings identified by the investigation.

Case reference 201100100

Other reports – Not Upheld

January 2013 – Clinical treatment in hospital – Cwm Taf Health Board
Mrs A complained about the way in which her right eye cataract surgery was carried out. She said that the surgeon was inexperienced and that she was soaked during the procedure. She had suffered with headaches since the operation. (Since making her complaint Mrs A has been diagnosed with Giant cell arteritis - an inflammatory disease of the blood vessels most commonly affecting the arteries of the head - the symptoms of which can include severe headaches).
The Ombudsman did not uphold Mrs A's complaint. He found, based on advice from his professional adviser - an experienced consultant opthamologist - that Mrs A had suffered a known complication during the operation which was clearly recognised and appropriately dealt with. The final visual outcome following surgery was good. It was unfortunate that Mrs A was wet from the fluid used to irrigate the eye during the surgery but it could sometimes happen and the Health Board had apologised. The Ombudsman accepted his professional advice that there was no link between the cataract surgery and Mrs A's recently diagnosed condition; the symptoms of which commonly included severe headaches. The Health Board agreed to apologise to Mrs A for information given about the procedure during the complaint handling, which was confusing.
Case reference 201200865

January 2013 – Clinical treatment in hospital – Cwm Taf Health Board
Mr W complained that he was unhappy about his clinical management at a Health Board's hospital in the time leading up to his undergoing a laparotomy (a surgical procedure involving an incision through the abdominal wall to gain access to the abdominal cavity, often undertaken to stem bleeding following trauma to the abdomen), which was undertaken some hours after his admission to the Emergency Department (ED). There had been additional problems in contacting those on call from the surgical team to review him in the first instance. Mr W had been kicked by a horse and a scan revealed a haematoma (a collection of blood/clot) in the mesenteric artery (the main artery arising from the part of the aorta - chief blood vessel of the body - in the abdomen). He considered that the surgical Registrar treating him (who no longer works for the Health Board) ought to have transferred him to ITU and/ or arranged for earlier surgical intervention by the Consultant. Mr W was unhappy with the results of the Health Board's own investigation of his concerns.

The investigation found that initially adopting a "wait and see" approach for Mr W was reasonable practice as this often resulted in such a situation resolving itself. The Ombudsman's clinical adviser confirmed the matter was a question of clinical judgment for the treating doctor at the time. Mr W could not be transferred to ITU as there were no beds. The adviser confirmed that the 15 minute observations needed could be better performed within the ED, as opposed to a routine ward, so there was no adverse effect to Mr W remaining there. When Mr W was no longer stable (his blood pressure having dropped a number of times), the Consultant was called in and a laparotomy performed. The adviser confirmed that Mr W had been managed in accordance with good practice throughout.

Whilst there had been initial problems in contacting the on call surgical team, this was due to a last minute change in the rota unknown to all the ED staff on duty. The Ombudsman proposed that the Health Board ensure on call rota changes were immediately communicated to both the Consultant and Senior Nurse on duty in the ED. They would be charged with cascading this to other staff and altering any shift record on display in the ED. There were shortcomings in the Registrar's recording in the clinical records, and the Health Board was asked to share this concern with him if he was still contactable. The Ombudsman did not uphold Mr W's complaints.
Case reference 201200726

August 2012 – Clinical treatment in hospital – Cwm Taf Health Board
Mrs H complained about the treatment her husband received in an Accident & Emergency Department after he was referred there with constipation. She complained that staff took insufficient notice of his previous history of cardiac problems and failed to properly investigate the possibility of a cardiac cause for his current symptoms. In particular, Mrs H complained that a troponin test was not carried out to check for damage to the heart. Mrs H said that her husband returned to the A&E Dept the following day, whereupon tests showed that he had suffered a heart attack. Mr H sadly died two weeks later.
The Ombudsman found that appropriate investigations and tests had been performed at the first A&E attendance and that the diagnosis and treatment Mr H received was appropriate given his symptoms at that time. The Ombudsman found that Mr H had not displayed any symptoms which should reasonably have led to a troponin test being considered necessary. The Ombudsman did not therefore uphold the complaint.
Case reference 201103337

July 2012 – Clinical treatment outside hospital – Cwm Taf Health Board
Mr R complained about his vasectomy procedure which was carried out by the Local Health Board under a service level agreement at his GP surgery on 29 September 2009. He questioned whether the decision to manage his post operative care conservatively was reasonable and appropriate. He also queried whether the ultrasound scan carried out on 13 October 2009 should have been carried out sooner and whether an earlier referral to an Urologist would have been appropriate.

The Ombudsman found that conservative management was appropriate in Mr R's clinical situation given that there was no evidence that his haematoma was continuing to expand. The Ombudsman found that there would not have been any benefit to Mr R had the ultrasound scan been carried out sooner than 13 October as it would not have had a material bearing on the clinical decision regarding his treatment. The Ombudsman was also satisfied that there was no clinical need (with specific reference to the vasectomy) which necessitated an earlier referral to a Urologist. The Ombudsman did not uphold the complaint.
Case reference 201102781

Quick fixes and Voluntary settlements

December 2012 – Clinical treatment in hospital – Cwm Taf Health Board
Mrs S complained about the treatment that her late mother, Mrs W, received whilst she was a patient at Prince Charles Hospital. Ms S complained about the attitude of a clinician who was involved in Mrs W's care. Ms S also complained that the family were not told that Mrs W was seriously ill, and that a more informed discussion as to whether Mrs W was to be resuscitated was not held. Mrs S complained that there were a number of outstanding questions which required a response from the Health Board.

Following consideration of the complaint, it was noted that the Health Board had provided a written response to the initial complaint. However, it did not appear that the questions which Ms S presented to the Ombudsman had previously been raised with the Health Board before making the complaint to the Ombudsman. Consequently, the Health Board had not been given the opportunity to fully respond to the complaint. The Health Board agreed to provide Ms S with a written response within 30 working days.
Case reference 201203456

August 2012 – Clinical treatment in hospital – Cwm Taf Health Board
Ms T complained that, after my office had referred her original complaint to be put through the Health Board's complaints procedure, she had not yet received a final response from the Health Board. My office contacted the Health Board, which agreed to send its final response to the complainant that day.
Case reference 201201653