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Chapter 1
Foreword

1.1 Last year, I published my first Annual Report as Welsh Administration Ombudsman and, for the first time, I published my Annual Report as Health Service Ombudsman for Wales separately from my Annual Reports as Health Service Ombudsman for England, and for Scotland. This year I have decided to combine my Annual Reports as Welsh Administration Ombudsman and Health Service Ombudsman for Wales in a single volume. I do so, with the agreement of the National Assembly for Wales, because my Office has increasingly integrated the handling of all complaints put to me in either capacity. There are also many issues and lessons to be learned from my work that are relevant throughout the public service; for example, the importance of good communication.

1.2 In Chapters 3 and 6 I discuss my Office’s workload and performance for the year. Overall, workload increased during 2000-01, although the proportion of it that arose in my capacity as Health Service Ombudsman was greater than expected. My policy is to train the staff in the Cardiff Office to deal with both Health Service and Welsh Administration complaints. The fact that they are able to operate effectively within both jurisdictions has enabled me to contain the additional Health Service work with the minimum of disruption.

1.3 Although there have been changes of personnel during the year, the total number of staff employed remains at nine. Although my investigations are to do with particular events, many of the cases that I investigate are concerned with the same general themes. Chapters 4 and 7 of this report address some of those: agriculture and the payment of grants; nursing and medical care; and good communications - a theme that was also highlighted in my last report as Health Service Ombudsman for Wales. I include in Chapters 5 and 8 summaries of all the cases investigated.

1.4 As I have said in previous Annual Reports, it is inevitable that my investigations will disclose shortcomings. Even so, it is relatively uncommon that such shortcomings are the fault of individual members of staff: much more often, they are the result of deficiencies in systems or shortage of resources. I deplore attempts to 'name and shame' in such circumstances: not only are they unfair, they foster a culture in which it is actually more difficult to improve services. And the fact is that the overwhelming majority of the staff employed by the bodies within my jurisdiction are devoted public servants who do their jobs extremely well.

1.5 The increased workload, training new staff, and the changes in working practices which I began last year and have further developed this year, have presented a considerable challenge to my staff. I am grateful to them for their enthusiasm and readiness to accept the changes necessary to respond to these challenges and to make them successful. The achievements set out in this Report are theirs.
My office has a commitment to staff training

Staff of the Ombudsman's Office
Levels of activity

2.1 As Welsh Administration Ombudsman I received 49 complaints during 2000-01. That was fewer than expected for I had received almost as many (46 complaints) during the nine months from July 1999 to March 2000. The reason for the decrease is not known; but the National Assembly for Wales issued its Code of Practice on Complaints during the year, and it may be that as a result complaints are now being handled better by the Assembly’s staff, thus obviating the need for subsequent referral to me. Nine (18%) of the complaints I received went to statutory investigation.

2.2 As Health Service Ombudsman I received 162 complaints, compared with 146 in 1999-00, an increase of 11%. That was a higher increase than in Great Britain as a whole; and it is the highest annual number of complaints my Office has ever received about the NHS in Wales. Compared with the number of episodes of health care, however, it is still a very small number. In keeping with the policy initiatives set out in my last Annual Report, I have continued to shift the presumption towards investigation when complaints are not obviously outside my jurisdiction, or premature because they have not been put to the NHS body or practitioner concerned. Accordingly, I accepted 25 complaints for investigation, some 30% of the investigable complaints I received.

That compares with less than 13% two years ago. In addition, I took action short of investigation for the benefit of complainants in a further 14 cases.

Developing the Ombudsman service

2.3 As Welsh Administration Ombudsman, I have introduced major changes to the Office’s working practices. The principal change greatly extended the delegation of signing powers to staff. A named investigator under the guidance of the investigations manager now generally takes responsibility for the progress of a complaint from receipt to resolution. The investigations manager can now verify and report the results of all but the most complex statutory investigations. Investigators normally now issue letters reporting the outcomes of all other considerations of complaints and routinely keep complainants informed of the progress of investigations.

2.4 My staff have also introduced a wider range of responses to complaints, matching outcomes to the individual circumstances of the case. Following an initial scrutiny, many complaints cannot be considered further because the body complained against or the subject matter of the complaint is clearly outside my jurisdiction. Sometimes, even when the complaint is within my jurisdiction, it is decided, after further consideration, not to take the matter
further, for example, if there is no evidence of maladministration resulting in an unremedied personal injustice, or no worthwhile outcome is likely. As an alternative to starting a statutory investigation further enquiries are sometimes made of the National Assembly, or the agency concerned, which result in an appropriate outcome for the complaint. It is evident from the reaction of complainants and the bodies complained against alike that many appreciate the benefits of this approach. Further enquiries can also result in the complaint not being taken further, for example, because they establish that no injustice has been suffered or no worthwhile outcome is likely. When a statutory investigation is initiated, my Office issues a statement of the complaint to the body concerned. The investigation process may be ended when an appropriate outcome has been achieved or no remedy is available; or it may be completed by the issue of a statutory investigation report to the complainant and the body complained against, which has previously had the opportunity to comment on the facts to be reported and their presentation. When it is possible to resolve complaints without issuing a statutory report, the investigator sends to the complainant and the body complained against a brief account of the main points agreed.

2.5 In my last Annual Report as Health Service Ombudsman for Wales I outlined plans to review the Office’s working methods and focus on changes that would make our processes more responsive, accessible, transparent and speedier. Steps have been taken to streamline our investigation processes; but it is too early to assess their full impact on the speed with which we complete cases. Communications with complainants, and those complained about, at all stages of the process have been reviewed and changed in ways that promote openness and easier exchanges with the parties to complaints. Reviewing the criteria for deciding whether to investigate a complaint has brought about a very significant change in the Office’s workload.

Review of public sector Ombudsman services in Wales

2.6 In last year’s Annual Reports I referred to the Review of Public Sector Ombudsmen in England, which had recently been published; and I suggested that the Review’s findings were equally applicable to Wales. I was pleased, therefore, when the National Assembly for Wales announced on 20 March 2001 that it was to undertake a similar review of public sector Ombudsman services in Wales. I look forward to the outcome of that review, and to working with the National Assembly in whatever new arrangements are introduced.

Human Rights Act 1998

2.7 The Human Rights Act 1998 came into force on 2 October 2000. I am often asked what effect that is likely to have on the work of the Office. My answer is that I do not expect it to have a significant direct effect. Ever since its establishment, my Office has sought to promote the values of fairness, due process, proportionality, and respect for the legitimate interests of individual citizens which the Act embodies.
However, as from 2 October all public authorities within my jurisdiction are obliged as a matter of law, and not only good practice, to consider the possible bearing of Convention rights on their decisions; and failure to do so will constitute maladministration.

**Retired family health service practitioners**

2.8 The Health Service Commissioners (Amendment) Act 2000 blocked a loophole to which I had previously drawn attention, whereby a family health service practitioner who had ceased to provide NHS services because of retirement or otherwise was not subject to my jurisdiction as Health Service Ombudsman as regards complaints about those services. I am pleased that this anomaly has been corrected.

**Publicity**

2.9 I am keen to continue to increase awareness of my Office’s functions and activities, so I was pleased when the National Assembly for Wales gave a wide circulation to last year’s Annual Reports. In August 2000, I published, for the first time, an occasional newsletter about my work as Health Service Ombudsman. My staff also contributed to a newsletter issued by the National Assembly’s Health Department to NHS bodies in Wales, for those involved in complaint handling. I would welcome comments and suggestions on any of my publications. In March 2001 I arranged a second seminar for Assembly Members and their staff. The seminar was well received and will, I hope, have given the participants a clearer understanding of my roles. My staff have also given a number of presentations about my work to staff of the Assembly, and NHS bodies throughout Wales.

**Review of the NHS complaints procedure**

2.10 The research team commissioned by the UK Health Departments to evaluate the working of the NHS complaints procedure reported to the Departments in March 2001. The report and its recommendations is the subject of widespread consultation by the National Assembly; and I await further developments with interest. Any changes which come about as a result of the evaluation exercise could have an impact on my work as Health Service Ombudsman in the coming year.

**The customer survey**

2.11 I continue to survey a proportion of all those who write to me as Health Service Ombudsman, and the complainants and respondents involved in all investigations, and ask about their experience of contact with my Office. More than 34% of those surveyed responded to questions about the timeliness and clarity of communications, about the work of my staff and about their satisfaction with the service provided by my Office. Comments were generally favourable this year, although the people whose complaints were upheld expressed satisfaction with our work more often than others. That said, there were justifiable concerns about the length of time taken to complete an investigation.
2.12 I have made some changes to the survey itself, so that the information that can be drawn from it is even more helpful. But I believe that it is important that surveys of this type should be complemented, from time to time, by a more broadly based survey of opinion about our work conducted by an independent organisation. For this reason I plan to commission such a survey during 2001-02.

Vexatious and unreasonably persistent complainants

2.13 One issue which is frequently raised with me, particularly on the health side, is dealing with complainants who are unreasonably persistent or vexatious. Most complainants behave entirely reasonably. However a few do not. They may, for example, abuse or threaten members of staff or continue to raise new questions when their previously stated concerns appear to have been fully addressed. A point can come, even with a complaint put in a courteous and reasonable manner, at which it has to be accepted that no purpose will be served by further exchanges. All organisations, including my own, have to be mindful that they have responsibilities to their staff and to others who use their services as well as to the complainant of the moment. A growing number of organisations are devising policies for managing such situations. I welcome this. It is desirable that any restriction placed on complainants should be the result of a fair and consistent policy, and that complainants should be regarded as vexatious or unreasonably persistent only for good reasons, and not just because they are forceful and determined.

2.14 In my view, such a policy should, among other things, pay regard to the following:

a Regardless of the manner in which the complaint is made and pursued, its substance should be considered carefully and on its objective merits.

b Complaints about matters unrelated to previous complaints should be similarly approached objectively and without any assumption that they are bound to be frivolous, vexatious, or unjustified.

c If a complainant is abusive or threatening, it is reasonable to require him or her to communicate only in a particular way - say, in writing and not by telephone - or solely with one or more designated members of staff; but it is not reasonable to refuse to accept or respond to communications about a complaint until it is clear that all practical possibilities of resolution have been exhausted.

d It is good practice to make clear to a complainant regarded as unreasonably persistent or vexatious the ways in which his or her behaviour is unacceptable, and the likely consequences of refusal to amend them, before taking drastic action.

e Decisions to treat a complainant as unreasonably persistent or vexatious should be taken at an appropriately senior level; and senior management should monitor such decisions.
3.1 Figure 1 shows a breakdown of my workload as Welsh Administration Ombudsman. In addition to the 49 complaints that I received during the year my staff dealt with 11 complaints brought forward from 1999-00. They cleared a total of 45 cases, including the completion of eight statutory investigations. A further nine investigations were started and remained in progress at the year end; six cases were still being considered. In addition, my Office dealt with eight written enquiries.

Figure 1 - Complaints received, screened and investigated in 2000-01
3.2 Figure 2 gives a breakdown of the workload, by the body complained about, showing how complaints were concluded. As was the case last year, I received complaints against various National Assembly departments, and a number of other Welsh bodies. Interestingly, however, the Assembly’s Agriculture Department accounted for a much smaller proportion of complaints than it did last year, although it remained the department most often subject to complaint. Last year the Agriculture Department accounted for 37% of the complaints I received; this year it was only 17%. As before, most of the complaints were about the non-payment of subsidies. It seems likely that this reduction in agriculture complaints is a consequence of the action taken by the National Assembly to improve complaints handling, to which I referred in Chapter 2; but that cannot be certain. It will be interesting to see whether the reduction continues in future years. Complaints to the Ombudsman may also be affected by the European Subsidies Appeals Mechanism for Farmers in Wales, which the Assembly is proposing to introduce later this year. I also received a significant number of complaints against the Transport, Planning and Environment group of the National Assembly; but these were mostly concluded without a statutory investigation.

![Figure 2 - Outcome of complaints 2000-01](image-url)

<table>
<thead>
<tr>
<th>Bodies complained about*</th>
<th>Cases carried forward from 1999-00</th>
<th>New Complaints</th>
<th>Concluded without Investigation</th>
<th>Investigations Justified</th>
<th>Not Justified</th>
<th>Total Carried forward to 2001-02 Screening</th>
<th>Investigations</th>
<th>Carried forward</th>
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</table>
| **This figure does not provide a comprehensive list of bodies within the Ombudsman’s jurisdiction.**

**Bodies outside the Ombudsman’s jurisdiction.**

***Includes complaint about access to official information.

‡ The total figure may be higher than the number of complaints shown in figure 1 as complaints may concern more than one body.
Figure 3 gives a breakdown of the 37 cases which were concluded without a statutory investigation. In about a third of them either the body complained about or the subject of the complaint was outside my jurisdiction. Many complaints concerned the action of local authorities; and in those cases the complainant was advised to contact the Local Government Ombudsman. In nearly 50% of cases it was found on examination, sometimes after making further enquiries, that there was no prima facie evidence of maladministration.

A Review of the Office’s achievements against the Business Plan

The targets and objectives set out in my Office’s Business Plan 2000 - 01 were designed to help achieve four essential aims when fulfilling my statutory functions:

- to be responsive to those with whom the Office has dealings;
- to be transparent in our work;
- to respond to the parties to complaints more quickly; and
- to increase cost effectiveness.

Targets for screening and considerative work before an investigation in the 2000-01 Business Plan were:

- All cases clearly out of jurisdiction to be identified and the complainant informed within two weeks.
- 60% of complaints not clearly out of jurisdiction to be resolved or be the subject of a formal statement of complaint being put to the body complained against within six weeks of receipt of the complaint.
- All but a handful of such complaints to be resolved or be the subject of a formal statement of complaint within 13 weeks.

Although exacting, the target of 100% for cases clearly out of jurisdiction was met. The target of 60% was comfortably exceeded, with 81% of complaints not clearly outside jurisdiction receiving a substantive reply or decision to investigate within six weeks.

<table>
<thead>
<tr>
<th>Figure 3 - Cases concluded without statutory investigation 2000-01</th>
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<tr>
<td><strong>Number of cases</strong></td>
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<tr>
<td>Body complained of outside Ombudsman’s jurisdiction</td>
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<td>Complaint not about administrative actions</td>
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<td>No prima facie evidence of maladministration</td>
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<td>Complainant had a right to appeal to a tribunal</td>
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<tr>
<td>Subject-matter of complaint not in jurisdiction</td>
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<td><strong>Total of cases concluded</strong></td>
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1 Includes ‘public service personnel matters’ and ‘contractual or commercial transactions’
weeks. The final target recognised that some cases are complex or require an unusual amount of background research before a decision can be made. A decision whether to investigate them cannot always be reached within the usual period of six weeks. However, in 2000-01 only one such case took longer than three months for a decision to be made.

3.6 The proportion of new complaints taken to investigation was 18%, only slightly lower than the 22% that were investigated last year. For such complaints the targets were:

- Completion to take on average no more than between 10 to 11 months from when sufficient information was received to enable the statement of complaint to be issued.
- To have no more than a handful of investigations over 12 months old at any stage.

In the event, the throughput time for cases completed during 2000-01 was 44 weeks. At the year end, there were only two investigations over 12 months old.

3.7 The priorities for 2001-02 are to improve on last year’s performance; and targets have been revised accordingly. Specifically, the Office aims to:

- explain quickly and clearly to complainants whether we are able to investigate their complaints and what action will be taken;
- achieve resolution of complaints efficiently and report the results in an appropriate and timely way; and
- improve transparency and effectiveness of the process by which complaints are resolved.

Put simply, our overall objective remains to deal with more cases and to deal with them faster.
During 2000-01 I completed eight statutory investigations. All but one were into complaints against the former Welsh Office Agriculture Department (WOAD) and were concerned with the administration and payment of subsidies under various EC Common Agricultural Policy (CAP) schemes, a theme that continued from 1999-00. Four of the investigations involved either the refusal or delay in payment of the Sheep Annual Premium subsidy. The full texts are included in Chapter 5.

R.42/99-00
Mr A, who claimed Sheep Annual Premium (SAP) and Hill Livestock Compensatory Allowance (HLCA) in respect of 1000 animals, was refused payment amounting to £27,000 because of a shortfall in the number of animals seen by WOAD’s inspector. He said that, because of sheep-rustling, he had difficulty maintaining proper records; and that he was not aware of the need to record stolen sheep. The Ombudsman found that record-keeping requirements were clearly set out in the regulations and guidance; and that Mr A was aware of those requirements. He concluded that WOAD had not acted maladministratively in withholding payment. He was concerned, however, that the extent of the penalty was determined by the size of Mr A’s claim, rather than the seriousness of the failings. In the light of the Ombudsman’s findings, the National Assembly decided to make an exceptional payment to Mr A for the amount of his HLCA claim. They also undertook to discuss with the other UK agriculture departments the appropriateness of withholding the full payment of SAP in such cases, or whether withholding a part of the payment would be more appropriate.

R.50/99-00
Mr and Mrs B complained that, although they had claimed Sheep Annual Premium for 1998 in January of that year, they did not receive payment until September 1999. The Ombudsman found that the claim was one of a number that WOAD were unable to process immediately because they had wrongly allocated Mr and Mrs B’s sheep quota to a trading title rather than to an individual in 1993. WOAD had intended to deal with these claims once the main run of claims was processed, but Mr and Mrs B’s claim was not reviewed until October 1998. It was then found that Mr and Mrs B had not been asked to complete a required declaration about their business structure. Mr and Mrs B were eventually asked to complete the declaration in April 1999, and they did so immediately, but payment was not made until September. Following the Ombudsman’s intervention, the National Assembly apologised and made a compensatory payment of £142 to Mr and Mrs B for WOAD’s delay in reallocating quota.
4.2 Two completed investigations concerned claims submitted under the Beef Special Premium Scheme. Administrative delay - in processing an application for cattle identification documents - was also a factor in one of those cases. The other provided an example of where better communication might have prevented the situation that gave rise to the complaint.

R.20/99-00
Mr C, who had made a claim under the Beef Special Premium Scheme (BSPS), was penalised because WOAD’s inspector recorded a particular animal as missing when he carried out his inspection. Mr C was sure that the animal, which was readily identifiable because it bore the marks of an earlier serious injury, had been inspected. The Ombudsman examined all the relevant documents and took evidence from those who were present, but he could not resolve the conflicting evidence about whether or not the bullock was presented for inspection. He found, however, that better communication by the inspector during the inspection might have allowed the matter to be resolved at the time. The National Assembly accepted that there was some breakdown in communication between Mr C and the inspector. In recognition of the consequent injustice Mr C suffered, they made him an ex gratia payment of £117.20, equal to the premium value of the animal in dispute.

4.3 Only one completed investigation did not have an agricultural theme. That was a complaint against the Planning Division of the National Assembly; that there was undue delay in issuing a planning decision. I found no maladministration in the process and upheld the complaint only to the extent that the National Assembly should have kept the applicant better informed as to progress.

R.2/00-01
Mr and Mrs D’s application for planning permission, to convert the remains of a derelict farmhouse and outbuildings, was called in for determination by the Planning Division of the National Assembly on 15 July 1999; but the decision was not made until 25 May 2000. Mr and Mrs D complained that that was an undue delay, but the Ombudsman found no evidence of maladministration. He found that, before the application could be decided, the National Assembly had introduced new procedures under which planning decisions were taken by a specially selected and trained cross-party committee; but then, because of a subsequent cabinet re-shuffle, new members had to be trained before the Committee could sit. He concluded that the delay had occurred because of a unique set of circumstances which limited the Planning Division’s ability to process the application. The National Assembly recognised that they should have kept Mr and Mrs D better informed as to when their application was likely to be decided.
Case No. R.42/99-00
The former Welsh Office Agriculture Department (WOAD)

Unreasonable refusal to pay Sheep Annual Premium and Hill Livestock Compensatory Allowance

Summary of case
In 1998, Mr A claimed Sheep Annual Premium (SAP) for 1000 animals. During an inspection visit in May, the inspector recorded a shortfall in the number of animals seen. Mr A was told that his claims for SAP and Hill Livestock Compensatory Allowance (HLCA) would not be paid as he had not kept proper records. Mr A contended that he had had difficulty maintaining proper records because of the problem of sheep rustling on his farm, and that he had not been aware of the need to record stolen sheep. The payments withheld amounted to £27,000.

Findings
As part of the Ombudsman’s investigation, the relevant regulations and instructions for record-keeping were examined. These gave detailed information about the records that producers must maintain, including the total number of sheep held on 1 January each year, with reasons given for any changes in the total number. In addition, while regular counts of sheep were not required, identified losses must be recorded. It was clear that Mr A had identified losses, as he had reported the apparent theft of sheep to the police. Within his claim form for SAP and HLCA, Mr A had signed an undertaking to maintain flock records as required by the regulations. An explanatory booklet produced by WOAD in 1996 emphasised that SAP would not be paid if proper records were not maintained. Mr A agreed that his records were muddled, but contended that they contained the relevant information. WOAD did not agree, and nor did the Ombudsman, who concluded that WOAD had not acted maladministratively in withholding payment. The Ombudsman also concluded that Mr A was aware of the record-keeping requirements. However, the Ombudsman was concerned at the extent of the penalty, which was determined by the size of Mr A’s claim, rather than the seriousness of the failings.

Remedy
The National Assembly for Wales (NAfW) decided to make an exceptional payment to Mr A for the amount of his HLCA claim. NAfW also reported that they would be discussing with the other UK agriculture departments the appropriateness of withholding the full payment of SAP in
such cases, or whether withholding a part of the payment would be more appropriate.

Case No. R.50/99-00
The former Welsh Office Agriculture Department (WOAD)

Unreasonable delay in payment of Sheep Annual Premium (SAP) 1998

Summary of case
Mr and Mrs B first claimed SAP in 1993 as a ‘sole producer’ and, in the name of their business, were allocated 90 units of quota from the National Reserve. Between 1993 and 1997, their SAP claims were processed and paid without difficulty. In January 1998, they submitted their 1998 claim to WOAD’s Divisional Office in Caernarfon. The claim was not processed immediately as it was identified as one where, in 1993, WOAD had wrongly allocated quota to a trading title, whereas quota had to be held by an individual. The Divisional Office filed Mr and Mrs B’s claim with other claims which could not be immediately processed, intending to deal with them once the main run of claims had been processed. However, Mr and Mrs B’s claim was not reviewed until October 1998. On 16 April 1999, WOAD wrote to Mr and Mrs B asking them to complete a declaration form detailing the structure of their business; Mr and Mrs B returned the form to the Divisional Office on 26 April. However, Mr and Mrs B did not receive their SAP payments until 16 September. On 4 October, Mr and Mrs B wrote to WOAD complaining about the delay and seeking payment of interest. WOAD apologised for the delay but refused to make an interest payment.

Findings
In a formal response at the start of the investigation, the Permanent Secretary of the National Assembly told the Ombudsman that he had reviewed Mr and Mrs B’s case. He considered that there had been unacceptable delay on WOAD’s part in re-allocating Mr and Mrs B’s SAP quota.

Remedy
As a result of the Ombudsman’s intervention the National Assembly apologised to Mr and Mrs B for the shortcomings identified and issued a compensatory payment of £142 for the delay in reallocating their quota.

Case No. R.20/99-00
The former Welsh Office Agriculture Department (WOAD)

Inspecting officer failed to record an animal presented for inspection

Summary of case
In August 1997, a WOAD inspector visited Mr C’s farm to inspect cattle for which Mr C had submitted a claim under the Beef Special Premium Scheme (BSPS). Mr C believed that, amongst other animals, he had presented a black limousin bullock for inspection; but the inspector did not record the bullock. The discrepancy became apparent at the conclusion of the inspector’s visit, so Mr C went to the field to search for the bullock; but by the time he located it the inspector had left. As a result, Mr C did not receive payment for the animal, and
penalties were applied to the rest of his claim.

Findings

The inspector’s field report of the inspection recorded that the bullock was missing at inspection. That report was signed by Mr C’s brother, who had assisted at the inspection. In an internal file minute written in October, the inspector confirmed that he had not seen the animal during his visit to the farm. Mr C and his brother told the Ombudsman that they were certain that the bullock had been presented for inspection. They remembered it because the animal was one of only two black limousin bullocks on the farm, and it bore the marks of a serious injury. They had discussed how well it had healed as it passed into the crush for inspection. When Mr C was told at the end of the inspection visit that the animal had not been presented for inspection, he went to look for it. He found the animal, but the inspector had already left. The Ombudsman was unable to resolve the conflicting evidence about whether or not the bullock had been presented for inspection. However, he considered that better communication by the inspector during the inspection might have allowed the matter to be resolved at the time. In particular, he found that the inspector could have told Mr C of the missing animal when all the animals had passed through the crush; that he should have been clear about how long he would give Mr C to search for the animal; and that he could have corrected an apparent misapprehension by Mr C that he would be able to put matters right after the inspection had concluded.

Remedy

The National Assembly accepted that there had been some breakdown in communication between Mr C and the inspector, and offered Mr C an ex gratia payment to the premium value of the animal in dispute.

Case No. R.2/00-01

The Planning Division of the National Assembly for Wales

Unreasonable delay in issuing planning decision

Summary of case

On 15 July 1999, a local authority resolved to grant Mr and Mrs D planning permission to convert the remains of a derelict farmhouse and outbuildings to form a single detached dwelling. On the same day the application was called in for determination by the National Assembly. On 30 November, a Planning Inspector appointed by the National Assembly to consider the application carried out a site visit; he submitted his report, recommending that permission should be refused, to the National Assembly on 15 December. On 22 December an official wrote to Mr and Mrs D telling them they would be notified of the outcome as soon as possible. At that time, Mr and Mrs D’s case was the only single-dwelling application before the National Assembly; ordinarily, the Assembly would have issued a decision on their application by the end of February 2000. However, on 19 January the National Assembly voted to introduce, with effect from 1 February, new procedures setting out how applications determined by the Assembly would be...
dealt with. Planning cases were to be decided by a specially selected cross-party planning development committee comprising four Assembly Members drawn from the Assembly’s Environment, Planning and Transport Committee (the committee) who had been specially trained to consider such cases. Then, a reshuffle of the National Assembly cabinet altered the composition of the committee; and training of new members was necessary before they could sit on decision committees. The decision on Mr and Mrs D’s application was made on 25 May.

Findings

The Ombudsman found that there was no evidence of maladministration to account for the delay in considering Mr and Mrs D’s application. It was rather that a unique set of circumstances encountered by the Planning Division limited their ability to progress the application. However, given the unique circumstances which prevailed the Ombudsman found that communication with Mr and Mrs D was inadequate. Mr and Mrs D were provided with information only as a result of their own enquiries. The Permanent Secretary told the Ombudsman that, with hindsight, the National Assembly should have written to Mr and Mrs D, even if they could not have given any substantive information.

Remedy

The National Assembly apologised to Mr and Mrs D for the shortcoming identified. The Permanent Secretary assured the Ombudsman that the National Assembly would in future keep applicants informed as to when their application was likely to be decided.

Case No. R.9/99-00
The former Welsh Office Agriculture Department (WOAD)

Unreasonable delay in notification of recovery of subsidy payment

Summary of case

In October 1996, Mr E, who already held five units of Suckler Cow quota, acquired a further 10.2 units by permanent transfer. On 6 December, Mr E submitted a Suckler Cow Premium (SCP) claim form for seven cows for the 1996 scheme year to WOAD’s divisional office. On 21 March 1997, WOAD confirmed, at Mr E’s request, that he held 15.2 units of quota. On 24 September, Mr E applied to lease seven units of quota to another producer for one year. On 13 November, WOAD told Mr E that because of apparent under usage of his quota in 1996, they proposed to withdraw 8.2 units of quota with effect from the 1997 scheme year. Mr E and, acting on Mr E’s behalf, the Farmers Union of Wales (FUW) appealed against this decision. However, on 5 December, WOAD confirmed the withdrawal of 8.2 units. On the same day, Mr E submitted a SCP claim for 1997, for eight cattle. On 21 January 1998, the quota section at WOAD’s divisional office notified the subsidy section of the withdrawal of Mr E’s quota; they also pointed out that Mr E’s remaining seven units had been leased out, so that there was no quota available to support his 1997 SCP claim. On 23 January, WOAD informed FUW of the situation and told them that, as
Mr E’s 1997 claim for SCP had already been paid, the subsidy section would shortly be writing to him about that. In the event, it was not until 12 March 1999 that the subsidy section wrote to Mr E requesting repayment of £1,275.91 paid to him in respect of his 1997 SCP claim. On 19 March, Mr E wrote to WOAD querying their delay in attempting recovery of the money. Mr E said that the circumstances in which his subsidy had been clawed back were the result of negligence on the part of the agent who supplied the quota. Mr E had reached an out-of-court settlement with the agent; but that had not included sufficient compensation for the loss of the 1997 SCP payment, which Mr E had assumed was not to be recovered.

Findings
There were apparent failings in the way in which WOAD had conducted the quota under-usage exercise, which according to WOAD’s guidance for SCP claimants, was due to take place in August and September 1997. In the event, WOAD did not confirm the withdrawal of Mr E’s quota until after the quota trading period had closed, thereby denying him the opportunity to acquire sufficient quota to cover his proposed SCP claim. Also, WOAD’s letter of 21 March 1997 contributed to Mr E’s incorrect belief that he held sufficient quota to be able both to lease out seven units and to support his subsidy application. WOAD accepted that, by October 1997, Mr E could reasonably have taken the view that he would not be penalised under the quota usage rules; and that WOAD had not advised Mr E of his lost quota quickly enough.

Remedy
The National Assembly apologised to Mr E for the shortcomings identified and agreed to pay his 1997 SCP claim of £1,275.81 in full. They confirmed that new arrangements for the amalgamation of subsidy and quota sections at the divisional office had been introduced and would alert staff to potential quota and subsidy problems at an earlier stage, thus avoiding a recurrence of the delays which occurred in Mr E’s case.

Case No. R.24/99-00
The former Welsh Office Agriculture Department (WOAD)

Refusal of payment of Sheep Annual Premium (SAP) 1998

Summary of case
On 6 January 1997, WOAD wrote to Mr F’s father, Mr G, informing him that after a recent review of allocations of quota which had incorrectly been allocated to a trading title rather than an individual, WOAD had re-allocated to Mr G personally 624 units of quota held in the name of his farming business. WOAD said that their action did not prevent Mr G from continuing to use his existing trading title or submitting claims for SAP in that name. On 30 April, Mr F submitted a 1997 IACS form using the business’s trading name in advance of taking over the business on his father’s retirement on 15 July. On 13 January 1998, Mr F submitted a claim for SAP for the 1998 scheme year giving the same business name. On 10 October, WOAD told Mr F that they were unable to pay his 1998 SAP claim because the quota was held by Mr G and had not been transferred to Mr F, and Mr F did not hold any
quota himself. Mr F asked W O A D to reconsider, as his father had sought advice from the Divisional Office before he retired and was told that, as the business name was not changing, he did not need to do anything more. He pointed to W O A D’s letter of 6 January 1997, and also argued that W O A D had accepted the 1997 IACS form without question and had checked the validity of his signature during a field inspection in February 1998. Despite further correspondence from Mr F and his MP, W O A D maintained that they were unable to pay Mr F’s 1998 SCP claim. W O A D said that they had investigated Mr F’s claim that his father had been given erroneous advice by Divisional Office staff, but that they were unable to identify anyone who had spoken to Mr G; the regulations were explicit; and the SAP claim could not be paid because Mr F did not hold quota to support his claim. At interview, Mr G told the Ombudsman’s investigator that he had made a general enquiry about the best time to retire in order to avoid loss of any subsidy; it appeared that he had made no specific enquiry about the need to transfer quota.

**Findings**

The Ombudsman did not uphold the complaint. He did not agree with Mr F’s contention that W O A D’s letter of 6 January 1997 misled him into thinking that he could claim SAP under the business name without the requisite transfer of quota. The letter had been addressed to Mr G personally and could not have anticipated his retirement later that year. Guidance issued by W O A D to SAP claimants set out clearly the requirement that quota had to be held by the individual making the claim; and Mr F acknowledged at interview that he had seen the guidance. Moreover, there was no evidence to suggest that Mr G made any enquiries of Divisional Office staff in terms such that they could reasonably have been expected to give information which would have prevented Mr G making an invalid claim for SAP. The Ombudsman also found that there was no substance to Mr F’s complaint that W O A D should have identified the problem at the time he submitted the 1997 IACS form. The registration of a holding with W O A D, through submission of an IACS form, is a basis for subsidy claims submitted during the year. A transfer of quota, which may or may not coincide with a transfer of holding, is a separate issue which W O A D cannot be expected to anticipate.

**Remedy**

As there was no finding of maladministration against W O A D, the Ombudsman did not recommend any redress.
Case No. R.31/99-00
The former Welsh Office Agriculture Department (WOAD)

Refusal of payment of Less Favoured Area (LFA) supplement due under the Sheep Annual Premium Scheme (SAP) 1998

Summary of case

On 21 January 1998, Mr H and his two sons, Mr J and Mr K, claimed SAP for 1998 in respect of 2,172 sheep held by them as a family partnership. They apportioned ownership of one third of the flock (724 animals) to each partner. On 14 May the partnership informed WOAD that they would not be submitting a 1998 Integrated Administration Control System (IACS) area aid application, because the partnership would be dissolved on 15 May due to Mr H’s retirement. On the same day, Mr J and Mr K submitted separate 1998 IACS applications for their respective holdings following the dissolution of the family partnership. On 26 August, WOAD informed the partnership that they had authorised payment of SAP for 1998; but that they could not pay LFA because the partnership had not submitted a 1998 IACS application. On 14 April, Mr H’s MP wrote to the Parliamentary Under Secretary of State (PUSS) at the Welsh Office on his behalf. The PUSS replied on 30 April that, although the SAP application could be considered valid, it appeared that officials had no discretion to pay the LFA supplement in the absence of a valid IACS application. He added, however, that officials were examining a number of similar cases, consulting colleagues at the Ministry of Agriculture, Fisheries and Food (MAFF) and obtaining legal advice on the matter. The PUSS told the MP that he would write further once the outcome of those deliberations was known. On 7 July, following the transfer of WOAD’s functions to the National Assembly, the MP wrote to the Agriculture and Rural Affairs Secretary asking whether the outcome of WOAD’s consultations was known. She replied on 27 July that the advice received was very clear and that European and domestic regulations did not allow for any waiver of the scheme requirements.

Findings

As a result of the Ombudsman’s intervention, the Permanent Secretary of the National Assembly reviewed the circumstances giving rise to Mr H’s complaint. He said that EU requirements in respect of applications for LFA supplement were clear and had to be supported by a declaration of the land used for sheep production, in the United Kingdom that was made by way of an IACS form. However, the Permanent Secretary had recently received legal advice that each producer within a partnership could be considered separately as a claimant to LFA. That being so, Mr J and Mr K, having submitted a valid IACS form, were entitled to their share of LFA. Unfortunately, Mr H remained ineligible for 1998 LFA because he did not submit a 1998 IACS application.

Remedy

The National Assembly reviewed Mr H’s case and agreed to recognise Mr J and Mr K as LFA claimants in their own right, thus enabling them to receive their share of the 1998 LFA supplement.
Case No. R.10/99-00
The former Welsh Office Agriculture Department

Delay in issuing cattle identification documents

Summary of case

On 7 September 1997 Mr L sent an application to WOAD’s Llandrindod Wells office for cattle identification documents (CIDs) and passports. Although passports were sent to him he did not receive CIDs for three steers. When he contacted WOAD on 19 April 1999 a member of staff admitted that although his application had been in order the CIDs had not been issued. He agreed to issue the CIDs that day, and advised Mr L to explain what had happened when he submitted a claim for beef special premium. Mr L submitted an application for first premium beef special premium the following day, but was later told that the three steers were too old to qualify for first premium and that it was the producer’s responsibility to ensure that they had received CIDs in time for first premium claim. Although Mr L appealed, WOAD upheld the decision not to pay premium. In their correspondence with Mr L they explained that the application form for CIDs advised applicants to contact WOAD within 14 days if documents were not received, and pointed out that Mr L had waited 19 months before contacting them. Mr L considered that WOAD had failed to meet their duty of care in ensuring that his application for CIDs was processed correctly and efficiently. As a consequence he had unreasonably been denied first premium payment on the three steers.

Findings

It was not clear why Mr L’s application for CIDs was not properly processed; but WOAD acknowledged that the administrative arrangements that existed at the time were unsatisfactory, since CIDs and passports, although applied for on the same form, were processed by two separate sections. The Ombudsman considered that WOAD had been responsible for the delay in issuing the CIDs. He also considered that that delay had effectively deprived Mr L of an opportunity to claim a payment to which he would otherwise be entitled. However, the Ombudsman recognised that Mr L’s own failure to follow advice given in the CID application, and to identify earlier that he had not claimed premium for the three steers, were relevant factors. That being so, the Ombudsman invited WOAD to consider offering Mr L an ex-gratia payment equal to 50% of the sum to which he would have been entitled.

Remedy

The National Assembly apologised to Mr L for the shortcomings identified and agreed to send him an ex-gratia payment of £132.06 in accordance with the Ombudsman’s invitation. They confirmed that new arrangements were now in place for the issue of combined cattle passports and identification documents.
Workload in 2000-01

6.1 In 2000-01 there was again an increase in the number of complaints received by my Office. A total of 162 were received, compared to 146 last year, an increase of 11%. Although the actual numbers are small, the percentage increase is appreciably greater than in England, where there was a 3% increase, and Scotland, where the increase was 4%. It is also appreciably greater than the 3.5% increase experienced in 1999-00. The position over the past ten years is illustrated at Figure 4. Figure 5 shows the number of complaints relative to population, and how that compares with NHS regions in England.

6.2 Workload for the year is analysed in Figure 6. The total screening workload shows an increase on last year of about 17%. This is because of an increase in cases carried forward from the previous year as well as the increase in new complaints received. (Note: the number of cases carried forward into 2000-01 varies slightly from that shown in last year’s Annual Report as some errors in classification have since been corrected.)
### Figure 5 - Geographical distribution of complaints received 2000-01

<table>
<thead>
<tr>
<th>Region of Origin</th>
<th>Number of complaints received</th>
<th>Proportion of Total (%)</th>
<th>Complaints per 100,000 population 2000-01</th>
<th>Number of complaints received</th>
<th>Proportion of Total (%)</th>
<th>Complaints per 100,000 population 1999-00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>229</td>
<td>8.8</td>
<td>4.23</td>
<td>274</td>
<td>10.8</td>
<td>5.06</td>
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<tr>
<td>London</td>
<td>576</td>
<td>22.2</td>
<td>7.91</td>
<td>496</td>
<td>19.6</td>
<td>6.81</td>
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<tr>
<td>North West</td>
<td>339</td>
<td>13.1</td>
<td>5.14</td>
<td>363</td>
<td>14.4</td>
<td>5.50</td>
</tr>
<tr>
<td>Northern and Yorkshire</td>
<td>263</td>
<td>10.1</td>
<td>4.15</td>
<td>277</td>
<td>11.0</td>
<td>4.37</td>
</tr>
<tr>
<td>South East</td>
<td>529</td>
<td>20.4</td>
<td>6.08</td>
<td>426</td>
<td>16.9</td>
<td>4.90</td>
</tr>
<tr>
<td>Trent</td>
<td>177</td>
<td>6.8</td>
<td>3.44</td>
<td>210</td>
<td>8.3</td>
<td>4.08</td>
</tr>
<tr>
<td>West Midlands</td>
<td>239</td>
<td>9.2</td>
<td>4.48</td>
<td>258</td>
<td>10.2</td>
<td>4.84</td>
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<tr>
<td>South West</td>
<td>214</td>
<td>8.2</td>
<td>4.34</td>
<td>212</td>
<td>8.4</td>
<td>4.30</td>
</tr>
<tr>
<td>Cases with no NHS Region</td>
<td>29</td>
<td>1.1</td>
<td></td>
<td>10</td>
<td>0.4</td>
<td></td>
</tr>
</tbody>
</table>

Total for:

<table>
<thead>
<tr>
<th>Region</th>
<th>Total (%)</th>
<th>Complaints per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>5.22</td>
<td>5.08</td>
</tr>
<tr>
<td>Wales</td>
<td>5.50</td>
<td>5.00</td>
</tr>
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</table>

### Figure 6 - Workload for the year

#### Screening work

<table>
<thead>
<tr>
<th>Category</th>
<th>2000/01</th>
<th>1999/00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints and enquiries brought forward</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Complaints received in year</td>
<td>162</td>
<td>146</td>
</tr>
<tr>
<td>Enquiries received in year</td>
<td>17</td>
<td>14</td>
</tr>
<tr>
<td><strong>TOTAL SCREENING WORKLOAD</strong></td>
<td>199</td>
<td>170</td>
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</table>

#### Outcomes (Non-investigatable)

<table>
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<tr>
<th>Category</th>
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<th>1999/00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enquiry answered</td>
<td>18</td>
<td>14</td>
</tr>
<tr>
<td>Not in jurisdiction</td>
<td>20</td>
<td>3</td>
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<tr>
<td>No action required</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Withdrawn</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Referred back and closed</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Premature - local action not exhausted</td>
<td>59</td>
<td>37</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>101</td>
<td>57</td>
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#### Outcomes (Investigatable)

<table>
<thead>
<tr>
<th>Category</th>
<th>2000/01</th>
<th>1999/00</th>
</tr>
</thead>
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<tr>
<td>No formal action</td>
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<td>54</td>
</tr>
<tr>
<td>Advice given to relevant body</td>
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<td>10</td>
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<tr>
<td>Further action agreed by relevant body</td>
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<td>3</td>
</tr>
<tr>
<td>Decision to conduct investigation</td>
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<td>24</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>84</td>
<td>97</td>
</tr>
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</table>

**TOTAL SCREENING DECISIONS TAKEN**

<table>
<thead>
<tr>
<th>Category</th>
<th>2000/01</th>
<th>1999/00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening cases carried forward</td>
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<td>22</td>
</tr>
</tbody>
</table>

#### Investigation Work

<table>
<thead>
<tr>
<th>Category</th>
<th>2000/01</th>
<th>1999/00</th>
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</thead>
<tbody>
<tr>
<td>Investigations brought forward</td>
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</tr>
<tr>
<td>New investigations begun</td>
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<td>24</td>
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<tr>
<td>Investigations discontinued</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL INVESTIGATIONS COMPLETED</strong></td>
<td>21</td>
<td>7</td>
</tr>
<tr>
<td>Investigations carried forward</td>
<td>21</td>
<td>20</td>
</tr>
</tbody>
</table>
6.3 Many complaints that come to me are not eligible for investigation. This year 55% of the complaints I considered fell into this category, whereas last year it was only 39%. This is a large increase, due mainly to a big increase in the number of complaints which were outside my jurisdiction, or had been put to me prematurely, before the NHS procedure was complete. It should be noted, however, that last year’s figure was unusually low. This year’s figure of 55% is not so unusual when compared with two years ago, when the figure was 46%. It is also significantly less than the number of ineligible complaints I receive as Health Service Ombudsman for England and for Scotland, where the figures are 68% and 61% respectively.

6.4 Of the 84 investigable complaints considered, I decided to investigate in 25 cases, giving a ‘take up’ rate of 30%, an increase on the 26.4% last year, which itself was more than double the previous year’s figure of 12.8%. As I have explained elsewhere, this continuing increase reflects my decision to shift the presumption towards investigation. That is very much to do with the nature of the cases coming to me. Of the cases I investigate, about 85% are to do with clinical care; and many of them involve serious and complex matters. One of the criteria I previously used to determine if a case (within jurisdiction) should be investigated was whether the complainant had produced prima facie evidence of maladministration or a failure to provide a service, or a failure in a service. It became clear to me that patients and their relatives were often not able to provide that evidence in relation to clinical complaints, and that I would have to begin an investigation, and take clinical advice, if I were to be sure that matters needing investigation were not overlooked by my Office. However, my staff remain conscious of the need to get the balance right between the risk of conducting unnecessary and fruitless investigations (and imposing unnecessary burdens on NHS staff) and the risk of denying complainants with valid unremedied complaints the investigation they deserve.

6.5 My staff took action short of investigation, for the benefit of complainants, in 14 cases. In eight cases they wrote to the health body with advice for improvement in future complaint handling; in the other six, health bodies agreed to take further action locally.

6.6 In the remaining 45 cases which were not investigated it was decided that further action by my staff was not warranted. These included cases in which, after careful scrutiny of the papers provided and after taking professional advice when clinical matters were involved, my staff considered that:

- the complaints had been adequately dealt with by the health body concerned and a commitment given, if appropriate, to act to improve practice in future; or
- further action would be unlikely to achieve any added benefit for the complainant; or
- there was no evidence that failings had led to unremedied injustice or hardship.
In those cases, complainants were given a full explanation of the decision including any necessary explanation of the clinical issue involved.

### 6.7

Figure 7 shows a breakdown of the complaints resolved in 2000-01 by health authority, trust or family practitioner category against which the complaint was made; and the way in which the complaint was resolved. Some complaints concerned more than one body. 16% of complaints were against family practitioners, roughly the same proportion as last year; but the number of those that were accepted for investigation has dropped. This year investigations were begun in only three family practitioner cases (11% of the total) whereas, last year, seven of the 21 investigations I completed concerned GPs. About 10% of investigable complaints came to me after having already been considered by an independent review panel. The remainder had not reached that stage because the convener had refused to grant a review. I received no complaints under the NHS Code of Practice on O penness.

<table>
<thead>
<tr>
<th>Health Body</th>
<th>Decision to conduct investigation</th>
<th>Further action agreed by health body</th>
<th>Advice given to relevant body</th>
<th>Other cases resolved</th>
<th>TOTAL</th>
</tr>
</thead>
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<tr>
<td>Bro Taf Health Authority</td>
<td>1</td>
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<tr>
<td>Dyfed Powys Health Authority</td>
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<td>Gwent Health Authority</td>
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<td>Iechyd Morgannwg Health</td>
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<td>2</td>
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<td></td>
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</tr>
<tr>
<td>North West Wales Trust</td>
<td>2</td>
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<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Pembrokeshire &amp; Derwen Trust</td>
<td>1</td>
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<td>2</td>
</tr>
<tr>
<td>Pontypridd &amp; Rhondda Trust</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Powys Healthcare Trust</td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Swansea Trust</td>
<td>3</td>
<td></td>
<td></td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Velindre Trust</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Welsh Ambulance Services Trust</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>GP</td>
<td>3</td>
<td>2</td>
<td>20</td>
<td></td>
<td>25</td>
</tr>
<tr>
<td>Dentist</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
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<tr>
<td>None/Unknown</td>
<td></td>
<td></td>
<td></td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>26</strong></td>
<td><strong>6</strong></td>
<td><strong>9</strong></td>
<td><strong>131</strong></td>
<td><strong>172</strong></td>
</tr>
</tbody>
</table>

*Note: The total number of complaints resolved may differ from those in Figure 6 because enquiries are excluded and some complaints concern more than one health body.*
6.8 I include, at Figure 8, an analysis by service area and subject of the number and type of grievances investigated. However, the numbers in each category are so small they should not be taken as being indicative of any trend. The categories broadly match those used by the National Assembly in their analysis of data on the operation of the NHS complaints procedure in Wales. Many investigations deal with more than one grievance e.g. clinical treatment and attitude of staff. In total, the 21 investigations completed in 2000-01 covered a total of 40 grievances, of which less than half (45%) were upheld wholly or in part. That compares with 1999-00, when 90% (of a much smaller number of grievances investigated) were upheld. The difference is not surprising given the greater presumption to investigation which I have discussed earlier in this report. However, it should be noted that in England, where there has been a similar increase in the take-up rate, and the number of investigations conducted is very much greater, some 69% of grievances were upheld, a figure not appreciably different to previous years. That may indicate that, because of the small numbers in Wales, it is not safe to draw conclusions on the basis of only one year’s figures.

Review of the Office’s achievements against the Business Plan

6.9 The Office’s 2000-01 Business Plan envisaged that the workload in 2000-01 would include 45 investigable cases and 20 completed investigations. As noted above the actual number of investigable cases was 84, and 21 investigations were completed. This necessarily affected the Office’s ability to achieve the targets in the Business Plan.

6.10 The Business Plan set two targets for the initial consideration of complaints:

- 75% of correspondence to receive a substantive reply within 18 working days; and
- all complaints to have a substantive reply, or a decision to investigate within two months.

As in 1999-00, the higher than expected proportion of investigable cases meant that the target of clearing 75% of correspondence within 18 days could not be achieved. In fact, 58% of correspondence was cleared within 18 days. The second target, which was markedly more taxing than the previous year’s target of three months, was also not met, only 85% of complaints receiving a substantive reply or decision to investigate within two months. Nevertheless, given the workload with which the Office was faced, that was a creditable performance.

6.11 The Business Plan also set two targets for the conduct of investigations:

- investigations to take an average of no more than 43 weeks to complete; and
- there to be no more than two uncompleted investigations more than 12 months old at the end of the year.
### Figure 8 - Grievances by service area and subject

<table>
<thead>
<tr>
<th>Category</th>
<th>Total upheld (wholly or partly)</th>
<th>Total not upheld</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital inpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upheld</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>Not upheld</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Hospital outpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upheld</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Not upheld</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Hospital A &amp; E</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upheld</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Not upheld</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Mental health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upheld</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Not upheld</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Maternity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upheld</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Not upheld</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Ambulance</td>
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<tr>
<td>Upheld</td>
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<td>1</td>
</tr>
<tr>
<td>Not upheld</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>General medical services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upheld</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Not upheld</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>General dental services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upheld</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Not upheld</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Community health (not covered by other category)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upheld</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Not upheld</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upheld</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Not upheld</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total upheld</strong></td>
<td><strong>12</strong></td>
<td><strong>10</strong></td>
</tr>
<tr>
<td><strong>Total not upheld</strong></td>
<td><strong>10</strong></td>
<td><strong>5</strong></td>
</tr>
</tbody>
</table>

**Total**

| Hospital inpatient                           | 16                              |
| Hospital outpatient                          | 8                               |
| Hospital A & E                               | 1                               |
| Mental health                                | 1                               |
| Maternity                                    | 1                               |
| Ambulance                                    | 1                               |
| General medical services                     | 10                              |
| General dental services                      | 1                               |
| Community health (not covered by other category) | 1                              |
| Other                                         | 1                               |
| **Total upheld**                              | **18**                          |
| **Total not upheld**                          | **18**                          |

**Total**

| Hospital inpatient                           | **16**                          |
| Hospital outpatient                          | **8**                           |
| Hospital A & E                               | **1**                           |
| Mental health                                | **1**                           |
| Maternity                                    | **1**                           |
| Ambulance                                    | **1**                           |
| General medical services                     | **10**                          |
| General dental services                      | **1**                           |
| Community health (not covered by other category) | **1**                          |
| Other                                         | **1**                           |
| **Total**                                     | **40**                          |
The increase in investigation workload over the last 18 months has meant that these targets, too, could not be met. The average time to complete investigations was 49.1 weeks, an increase on last year’s figure and appreciably above the target of 43 weeks. It should also be borne in mind, however, that 18 out of the 21 completed investigations were clinical cases compared with only two of the seven cases investigated in 1999-00. Experience has shown that, just as it is harder to identify quickly those cases in which clinical failings are most likely to be found, the investigation of clinical cases is significantly more time-consuming. Figure 9 analyses the

investigations completed in the last two years by the time taken to complete the investigation. The effect of the increased number of clinical cases is clearly seen when it is realised that the three non-clinical cases investigated this year are all included in the first two time bands, having been completed in 10, 23 and 31 weeks. The problems with keeping up with a large expansion of workload are also reflected in the age of investigations in hand at the year-end. At 31 March 2001, there were nine investigations over nine months old, including five that were over 12 months old. That will affect the 2001-02 figures as these will include many cases which were old at the beginning of the year.

Figure 9 - Time taken to complete investigations 2000-01

<table>
<thead>
<tr>
<th>Time Band</th>
<th>% completed</th>
<th>previous year (%)</th>
<th>Cumulative (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 30 weeks</td>
<td>14.3</td>
<td>57.1</td>
<td>14.3</td>
</tr>
<tr>
<td>30-35 weeks</td>
<td>14.3</td>
<td>0</td>
<td>28.6</td>
</tr>
<tr>
<td>36-45 weeks</td>
<td>14.3</td>
<td>14.3</td>
<td>42.9</td>
</tr>
<tr>
<td>46-55 weeks</td>
<td>19</td>
<td>14.3</td>
<td>61.9</td>
</tr>
<tr>
<td>56-65 weeks</td>
<td>14.3</td>
<td>0</td>
<td>76.2</td>
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<td>66-75 weeks</td>
<td>4.8</td>
<td>14.3</td>
<td>81</td>
</tr>
<tr>
<td>76-85 weeks</td>
<td>9.5</td>
<td>0</td>
<td>91</td>
</tr>
<tr>
<td>86-95 weeks</td>
<td>9.5</td>
<td>0</td>
<td>100</td>
</tr>
</tbody>
</table>

Average: 2000-01 - 49.1 weeks 1999-00 37.9 weeks
Chapter 7
Health Service Ombudsman for Wales: Themes from Cases

7.1 Although my investigations are to do with particular events, there are also themes that are common to many of the cases that my Office investigates. In this section of my report, I draw attention to three themes which have emerged from the complaints I have investigated in the past year: communication, medical care, and nursing care. I also refer again to complaints handling, a theme I addressed in last year’s report.

Communication

7.2 Poor communication lies at the heart of many of the complaints I receive. Sometimes it can result in patients or their relatives not being fully aware of the seriousness of the situation; subsequent distress could perhaps have been avoided. Sometimes a failure to listen to relatives and friends who say that a patient is ‘not usually like that’ or ‘looks much worse’ can lead to inadequate or delayed treatment.

7.3 In one case I investigated (W.58/99-00) a seriously ill woman was left without nutrition for several hours largely because of poor communication. In complaining to me, the woman’s husband said that he thought his wife was being denied sustenance, and was being allowed to die. In another case in which communication was poor (W.39/99-00), I could not be sure that a woman had fully understood the reasons for the operation that she underwent.

W.58/99-00
Mrs A, who had been admitted to hospital following a stroke, was receiving total parenteral nutrition (TPN) through a vein in her arm. Doctors then proposed that when the consultant responsible for her care returned from leave she should have a percutaneous endoscopic gastrostomy (PEG) to allow feeding through a tube in her abdomen. In the event, the consultant decided, on his return, that Mrs A was too ill to undergo the procedure. However, earlier that day, the TPN had run out, leaving her without nutrition. Because a staff nurse had written in the notes that TPN was to cease when the current bag was empty, no replacement TPN had been ordered. Nurses were not warned that the PEG might not go ahead; nor did they inform their medical colleagues that the TPN had ceased. As it happened, the period without nutrition had no significant effect on Mrs A’s condition; but TPN should not have ceased before an alternative method of feeding was agreed. With better communication, Mrs A’s husband might have been spared some of the distress he suffered.
Ms B was unhappy about a proposed laparotomy (an exploratory operation) and ventrosuspension (a surgical procedure to correct the angulation of the uterus) that she was scheduled to have. She asked about the possibility of an exploratory procedure instead. However, following discussion with the consultant at his clinic, it was decided to do a hysterectomy and bilateral oophorectomy. The advisers appointed to assist with the clinical aspects of the investigation were satisfied that the more major procedure was appropriate; but, by his own admission, the consultant’s limited consultation with Ms B did not allow him time to discuss the procedure and its implications fully. Although Ms B subsequently spoke to another doctor, when she signed a consent form for the operation, the Ombudsman could not be sure that she had fully understood the reasons for the operation to which she consented. There was also a lack of clarity about the procedure to be performed in the note the consultant wrote following his consultation. Finally, on the morning of the operation, when Ms B was still expressing doubts, she asked to see the consultant; but when her request was relayed to the consultant he advised only that she should go home if she had doubts. Ms B had personal reasons for not wanting to postpone surgery, so went ahead with the operation. The Ombudsman considered that, in the circumstances, an opportunity was missed to resolve the matter, and that it would have been prudent for the consultant to have seen Ms B personally.

The majority of cases I have investigated this year have concerned the actions of doctors, both hospital and GP. Many complaints have not been upheld, but sometimes the actions that have been taken and the judgements that have been made have fallen short of what patients and their relatives can reasonably expect. I have referred above to a case in which communication with the patient might have been better (W.39/99-00). In another case, shortcomings in monitoring and communication led to a woman undergoing a repeat procedure unnecessarily (W.128/99-00). I realise that clinicians are under considerable pressure because of their workload; nevertheless, it is important that they should have regard to all available information when deciding on a course of action. In two cases this year (W.86/99-00 and W.71/99-00) that was not done.

Mrs C was admitted to hospital with loin pain and difficulty passing urine. Tests confirmed a blockage in the kidney, and a blood infection. Antibiotics were prescribed, and a nephrostomy was performed to insert a tube into the kidney to allow urine to drain. Twice the tube became dislodged and was replaced. Shortly after the second replacement Mrs C deteriorated and died following internal bleeding. The Ombudsman found that on the third occasion on which the nephrostomy was performed, the indicators for that procedure were no longer present. The previous insertions had been difficult, and they had revealed
evidence of bleeding in the kidney. Mrs C’s blood platelets, which aid blood coagulation, were very low; but there was inadequate communication about that between doctors before the procedure. When, after the third procedure, low blood pressure was recorded, it was almost certainly due to haemorrhage; but that fact was not recognised at the time.

**W.86/99-00**

Mr D, who suffered from Parkinson’s disease and diabetes, was admitted to hospital after collapsing at home. As the days passed, his condition deteriorated; his hallucinations became worse; confusion set in; he suffered mood swings, incontinence, and dizziness; and he suffered injuries from falling over, including a broken hip. Mr D’s son was concerned about his father’s deterioration, and discussed his concerns with the doctor. He told the doctor that his father was being given too high a dose of medication, but the doctor dismissed his concerns. Mr D continued to deteriorate and died a few weeks later. The Ombudsman found that Mr D’s symptoms after his admission were the result of inappropriate drug treatment; and that that and the injuries he suffered as a result of the falls had contributed to his death. On admission, the examining doctor had seen clear evidence of Parkinson’s disease and judged that to have been the cause of Mr D’s fall at home. However, neither he nor a second doctor had made any formal assessment of Mr D’s mental state; and no effort was made to speak to Mr D’s GP to find out about his condition before he was admitted. Mr D’s son, who was very familiar with his father’s circumstances, frequently queried his father’s condition and the medication being given; but, for much of the time, his observations were ignored. The Ombudsman’s professional assessors advised that there was considerable evidence of drug-induced confusion and hallucinations; and that the medication should have been monitored more carefully.
Mr E’s two-year old son suffered from Rubinstein-Taybi-Syndrome (RTS) and required surgery to correct two features associated with the syndrome, undescended testicles and narrow or blocked tear ducts. Because it is also a feature of RTS that anaesthetics can cause reaction in both the heart and the lungs, the ophthalmic surgeon and the paediatrician agreed that both operations should be performed at the same time. The ophthalmic surgeon wrote to a general surgeon at the hospital where the operations were to be performed, who agreed to perform the orchidopexy (fixation of an undescended testis); but it appears that nothing was said to alert the general surgeon to the fact that the boy had RTS. On the day of the operation, after reading the boy’s notes, the general surgeon said that he would not perform the orchidopexy that day, because RTS was a rare condition with which he was not familiar, and it was necessary to do a scan first. The eye surgery went ahead as planned. The general surgeon recognised that he had erred in assuming that Mr E’s son had been appropriately assessed for the proposed surgery; and the Trust agreed to review their pre-operative checks to ensure that such an incident could not happen again.

Nursing care

7.5 Many of the complaints I investigate about clinical care include consideration of the care given by nursing staff. The contact patients have with nurses during their care is often greater than contact with medical staff, even sometimes for outpatients and patients visiting general medical practitioners. It is not surprising, then, that concerns about nursing care feature in many of the complaints coming to my Office. As always, I see examples of both good and bad practice.

7.6 One of the cases I investigated (W.10/99-00) highlighted the need for nurses to adjust their monitoring and care to the particular, and changing, needs of the patient. It shows, too, the importance of proper recording of that care; and good communication with relatives and medical staff. One of the cases I have referred to above, under ‘Medical Care’ (W.128/99-00), also shows that nurses need to heed their observations and take prompt action when necessary. In that case, although nurses made observations at half-hourly intervals in accordance with protocol, they did not ask a doctor to attend until after the third set of observations, despite the fact that blood pressure, which was particularly significant in Mrs C’s case, had remained low throughout that time.
Mr F, who had Alzheimer’s disease, was admitted to hospital when he developed a throat condition which affected his ability to swallow, and stopped drinking completely. He was discharged home next day, but was readmitted two days later after collapsing at home. Mr F’s daughter was originally told that he had suffered a stroke and had only a few hours to live; but, at first, Mr F’s condition improved. Two days later, he suffered a fatal heart attack. The Ombudsman found a number of failings in care. It was clear that, when he was admitted, staff expected Mr F to die soon; for that reason, perhaps, they drew back from intervening unnecessarily in the time his family had left with him. However, Mr F’s condition improved to the extent that he had obviously not suffered a stroke; but staff did not adequately amend or reassess their approach to his care. There was little communication with the family; and the frequency of observation was not sufficient, given that medical staff had asked for ‘close observation’. There was no indication in the records that staff had assessed Mr F’s swallowing ability or nutritional requirements, monitored nutritional and fluid intake, or encouraged the taking of food or fluids. A note in Mr F’s nursing records, made by a staff nurse, indicated that medical staff were too busy to re-sit Mr F’s intravenous drip when it became dislodged; but the ward sister told the Ombudsman’s investigator that the drip would have been difficult to replace because of Mr F’s restlessness and that, in any event, it was no longer needed as he had begun to take oral fluids. However, there was nothing to show that the discontinuation of the drip had been discussed with, and approved by medical staff, or that the decision and explanation were communicated to Mr F’s family. Not surprisingly, Mr F’s family was left with the impression that Mr F was receiving inadequate and inappropriate care.

Handling of complaints

7.7 In my last report, I drew particular attention to the handling of complaints, for I had seen many justified complaints about that, involving every aspect of the NHS complaints procedure, from interpretation of the Statutory Directions to the quality of reports produced by Independent Review Panels. This is an area in which my staff are often asked for examples of good practice, and the subject has been raised a number of times at training events at which they have participated. In the light of that, I include at Annex A to this report the markers of success in complaints management to which I have previously drawn attention.
Case No.W.58/99-00
The former Glan Hafren NHS Trust

Care of a woman stroke patient

Summary of case
Mr A’s wife was admitted to Caerphilly District Miners’ Hospital on 13 July 1998 following a stroke. Because she was unable to swallow, an attempt was made to feed her through a naso-gastric tube; but when that proved difficult doctors introduced total parenteral nutrition (TPN) through a vein in her arm. Mr A was told that his wife would be fed in that manner until 30 July, when the consultant returned from leave. A percutaneous endoscopic gastrostomy (PEG) would then be performed to allow feeding through a tube in Mrs A’s abdomen. On 30 July Mr A was shocked to be told by the consultant that the PEG would not be carried out as his wife was too ill. He also discovered that, despite the consultant’s decision not to operate, the existing TPN had already ceased and his wife was no longer being fed. When he raised that with the consultant, naso-gastric feeding was re-instated and continued until his wife’s death on 5 August. Mr A complained that inadequate arrangements had been made for meeting his wife’s nutritional needs, and that there had been unnecessary delay in arranging the PEG, which allowed his wife’s condition to deteriorate. He also had other concerns about the care she received, particularly in her final hours, and had made several requests for her to be transferred to a larger hospital nearby. He was aggrieved, too, that for much of her time in hospital he was unable to speak to a consultant.

Findings
The Ombudsman found that when the consultant had reviewed Mrs A’s condition, on his return, he had decided that the PEG procedure was too risky. The Ombudsman’s assessors considered that although TPN had adequately met Mrs A’s nutritional needs in the interim it would have been preferable, for technical reasons, to have inserted the PEG earlier. The Ombudsman upheld the complaint to that extent. He found, too, that communication failure, and unfamiliarity with TPN and ward procedures, had led to Mrs A’s TPN ceasing before an alternative method of feeding was agreed. However, the short interruption in feeding had not had a significant effect on Mrs A’s condition. The Ombudsman was not able to say whether or not Mr A’s inability to see the consultant was because of a failure in service. He considered it unnecessary to have transferred Mr A’s wife to another hospital for treatment or intensive care, except for a CT scan, which the assessors thought should have been performed. Mr A’s wife’s final...
hours were clearly traumatic for all concerned, but the staff had done what they could to minimise her distress.

**Remedy**

The Trust agreed to draw up protocols and give training to their staff about providing TPN. They also agreed to ensure that adequate arrangements existed to provide urgent procedures such as PEG insertion, and for CT scanning. They said that they would consider the introduction of a formalised tool for stroke assessment, and a more formal arrangement to ensure adequate consultant cover during leave periods; and they would reinforce to their staff the importance of good communication.

**Case No. W.39/99-00**

**The former Gwynedd Hospitals NHS Trust**

**Inappropriate removal of organs and uninformed consent**

**Summary of case**

On 23 December 1997 Ms B saw a consultant obstetrician and gynaecologist privately because of bowel and abdominal pain, loss of weight, and tiredness. The consultant arranged for Ms B to be admitted to Ysbyty Gwynedd on 29 January 1998, as a NHS patient, for a laparotomy (an exploratory operation) and possible ventrosuspension (a surgical procedure to correct the angulation of the uterus). Following a pre-assessment clinic on 20 January, Ms B was concerned about the proposed surgery and wrote to the consultant asking if she could have a laparoscopy (the introduction of a telescope through the umbilicus to inspect the abdominal and pelvic organs) instead. She understood that that was a lesser operation which would help her decide whether she wished to continue with more major surgery. The consultant discussed the matter with Ms B at his clinic on 26 January, following which it was decided to conduct a hysterectomy and bilateral salpingo-oophorectomy (BSO) (the removal of both left and right ovaries and the tubes connecting them to the uterus). When Mrs B was admitted to the hospital on 29 January, for operation the next day, she was seen by a senior house officer (SHO), who obtained her consent to that operation. However, Ms B remained concerned about the extent of the proposed surgery and asked to see the consultant. The consultant was contacted the following morning; and he told ward staff then to tell Ms B that if she was still unsure, she should go home and he would review her in clinic. Ms B decided to proceed with the operation; but she subsequently complained to the Ombudsman that a total hysterectomy and BSO had been carried out when it was not clinically appropriate, and without her informed consent.

**Findings**

The Ombudsman found there were aspects of what occurred which suggested that there was some misunderstanding between Ms B and the doctors about the nature of the operation that was eventually performed, and the reasons for it. He found it surprising that when the consultant met Ms B on 26 January to
discuss her concerns, it resulted in a decision to perform a total hysterectomy and BSO, a more major procedure than that which the consultant had originally advocated. However, the Ombudsman’s assessors advised that, given Ms B’s symptoms and her clinical history, the more major procedure was not unreasonable. While that may have been the case, the Ombudsman did not accept that the consultant’s change of plan had been adequately discussed at the time. The consultant himself admitted that it was a limited consultation, and that he had had insufficient time to explain the procedure, and its implications. The Ombudsman also had concerns about the actual extent of the surgery that was planned and performed. Following the consultation on 26 January, the consultant had written that Ms B was to come in for ‘Total Hysterectomy ± BSO’. The consultant said that that indicated a definite BSO, in that he had underlined the ‘+’. However, the Ombudsman’s assessors advised that the use of ‘±’ in normal medical parlance would indicate a degree of uncertainty, suggesting that the patient would only be agreeable to, as in this case, the removal of the ovaries if there were good reasons for doing so. The Ombudsman concluded that the consultant’s terminology was, at best, ambiguous. Although Ms B formally consented to the operation, and the SHO insisted that she had fully discussed the procedure when she obtained that consent, the Ombudsman had reservations about the level of Ms B’s understanding of what was to happen to her. However, in the light of the contradictory evidence he received on the subject of informed consent, he could make no finding on that aspect of the complaint. He considered that an opportunity was lost on the morning of the operation when it might have been prudent for the consultant to have seen Ms B as requested.

Remedy

The Trust agreed to remind all their doctors of the need to ensure that patients are given a full explanation of any proposed surgery and its associated risk or side effects; and to remind consultants that they have a personal responsibility for ensuring that that is done.

Case No. W.128/99-00

The former Morriston Hospital NHS Trust

Appropriateness of repeat nephrostomy and lack of monitoring following the procedure

Summary of case

In June 1998 Mr C’s mother was admitted to Morriston Hospital with loin pain and difficulty passing urine. Tests confirmed a blockage in a kidney and a blood infection. Antibiotics were prescribed; and a procedure known as nephrostomy was performed to insert a tube into the woman’s kidney to allow urine to drain. The tube displaced twice and was replaced each time. Shortly after the second replacement Mrs C’s condition deteriorated; and she died following internal bleeding. Mr C complained to the Trust about his mother’s care; but although an independent review was held he
remained dissatisfied. He asked the Ombudsman to consider whether it was appropriate to perform the second repeat nephrostomy, and in particular whether there was effective communication about the risks involved between the doctor who was responsible for his mother’s care and the doctor who performed the procedure. He also complained that his mother’s care following the procedure was inadequate, and that her condition was not satisfactorily monitored.

Findings

At the time Mr C approached the Ombudsman the Trust had not had the opportunity to respond to the conclusions of the IR panel. When he considered the complaints, therefore, the Ombudsman had regard to their findings and the action already taken. The Ombudsman’s medical adviser said, as had the clinical assessors to the panel, that she would not have performed the second repeat nephrostomy. She said that the indicators that existed for the initial insertion were no longer present; previous insertions had been difficult; and they had revealed evidence of bleeding in the kidney. The Ombudsman was advised that Mrs C’s blood platelets, which aid blood coagulation, were very low and that there had been inadequate communication between the doctors about that before the procedure went ahead. The Ombudsman also found that the significance of the woman’s low blood pressure on her return to the ward was not appreciated by those involved in her care, and that there were shortcomings in monitoring her condition. Unfortunately, although there was a failure to identify internal bleeding, there was very little that staff could have done at that stage to save Mrs C. The Ombudsman upheld both complaints.

Remedy

The Trust had already taken action to ensure that blood platelets were checked before nephrostomy, and that blood pressure was monitored before interventional procedures. They also agreed to ensure that that information was fully considered before the patient was sent for such procedures; to ensure that blood details and cross-matched blood was readily available; to monitor blood pressure after a procedure until the patient was stable; and to remind staff about the signs of haemorrhage. The Trust apologised to Mr C for the shortcomings identified by the Ombudsman.

Case No. W.86/99-00

The former Rhondda Health Care NHS Trust

Inappropriate drug treatment

Summary of case

Mr D, who had suffered from Parkinson’s disease and diabetes for many years, collapsed on 15 July 1998 and was taken to the accident and emergency department of East Glamorgan Hospital. He was discharged later that day, no explanation being given for his collapse. After collapsing twice more, Mr D was admitted to Llwynypia Hospital on 16 July. On admission it was noted that he was taking two different drugs for
Parkinson’s disease, Sinemet and Selegiline. As the days passed, Mr D’s condition deteriorated: his hallucinations became worse; confusion set in; he suffered mood swings, incontinence and dizziness; and he suffered injuries from falling over. Mr D’s son was concerned about his father’s deterioration, and discussed his concerns with the ward doctor. He told the doctor that his father was being given too high a dose of Sinemet; but the doctor dismissed his concerns and said that Mr D had been put on a new medication. On 5 August Mr D’s son was told that his father had broken his hip and would need an operation; this was undertaken but Mr D continued to deteriorate and died on 21 September. An independent review (IR) was held into Mr D’s son’s complaints about his father’s care. In their report, the IR panel said they were satisfied that, during his time in hospital Mr D’s Parkinson’s disease was ‘in its last and tragically irreversible stage’. Mr D’s son complained to the Ombudsman that, contrary to the IR panel’s view, Mr D’s symptoms from 16 July were the result of inappropriate drug treatment; and that that and the injuries he suffered as a result of the falls had contributed to his death.

Findings

Mr D’s son said that before being admitted on 16 July, his father was still fairly agile, showed no signs of confusion and had a good appetite; but that after admission there was a deterioration in his condition. The Ombudsman found that the doctor who examined Mr D on admission had seen clear evidence of Parkinson’s disease and judged that to have been the cause of his fall at home the previous day. He was concerned that neither that doctor, nor the doctor who saw Mr D the next day, made any formal assessment of Mr D’s mental state which, according to the Ombudsman’s assessors, would have been considered routine practice. He was also concerned that no effort was made to speak to Mr D’s GP to find out about Mr D’s condition immediately before admission, and his progress since 1996 when he was last reviewed in hospital. The assessors said that problems in Parkinson’s disease were individual and needed careful analysis; and they pointed to a number of instances in which Mr D’s particular circumstances were inadequately considered. Mr D’s son, who was very familiar with his father’s circumstances, had frequently queried his father’s condition and the medication he was taking; but for much of the time his observations appeared to have been ignored. There was considerable evidence of drug-induced confusion and hallucinations. The assessors said that these should have been monitored more carefully. Although there was no doubt that Mr D’s Parkinson’s disease was well advanced, the Ombudsman did not think it could reasonably be concluded that what happened after his admission on 16 July was solely attributable to the disease being in its last and irreversible state. He was persuaded, by the evidence he had taken and the advice he had received from his assessors, that what occurred to Mr D was, at least in part, a consequence of inappropriate drug treatment. He upheld the complaint.
Remedy

The Trust agreed to take note of the recommendations made by the Ombudsman's assessors, and to develop policies accordingly. They also accepted that clerked patients needed to be handed over properly to the doctor continuing their care; that the number of staff physicians needed to be reviewed to ensure adequate cover at all times; that patients with Parkinson's disease needed treatment of their problems as individuals and not by protocol; and that interdisciplinary working needed to be introduced as a matter of urgency. Although not part of the complaint investigated, the Ombudsman also shared with the Trust concerns raised by his nursing adviser in the course of the investigation: that the record keeping of nurses needed to be analytical, and the notes comprehensive; that remedial action was required to address nursing attitudes and interdisciplinary working practices; and that nursing observations needed to be better targeted, understood and shared with the whole inter-disciplinary team, with the care plan being reviewed and altered as the patient's condition required. The Trust brought these issues to the attention of the Director of Nursing in order that appropriate action could be undertaken.

Case No. W.71/99-00
Carmarthenshire NHSTrust

A surgeon's failure to inform himself about a patient's condition, or ensure that he was appropriately assessed, prior to his proposed operation

Summary of case

Mr E's son was born in May 1996 suffering from Rubinstein-Taybi Syndrome (RTS) and required surgery to correct two features associated with the syndrome, undescended testicles and narrow or blocked tear ducts. Because it is also a feature of RTS that anaesthetics can cause reaction in both the heart and lungs, the consultant ophthalmic surgeon and consultant paediatrician agreed that both the eye surgery and the orchidopexy (fixation of an undescended testis in the scrotum) should be performed at the same time in West Wales General Hospital (the hospital). The ophthalmic surgeon wrote to a general surgeon at the hospital, who replied that he would be happy to perform the orchidopexy. On the day of the proposed operations, after examining Mr E's son and reading his notes, the general surgeon said he would not perform the orchidopexy that day since RTS was a rare condition with which he was not familiar, and that it was necessary to do a scan first. The ophthalmic surgeon, however, went ahead and performed the eye surgery as planned.

Findings

Mr E and his wife were well aware of the risks in giving anaesthesia to their son; and they were therefore very
concerned when arrangements made to ensure that their son did not undergo anaesthesia more often than necessary broke down because the general surgeon was not prepared to continue when he learned that the boy had RTS. The Ombudsman's medical adviser told him that it is quite acceptable for a surgeon not to see a patient personally, or examine the patient's notes until immediately before the operation, provided that the proposed operation is straightforward. Clearly that was not so in Mr E's son's case; but nothing was said to alert the general surgeon to that fact; and he assumed that Mr E's son had been appropriately assessed for the proposed surgery before he was referred to him. But that had not been done. The general surgeon recognised that he erred in making that assumption; and the Trust said that they were reviewing their pre-operative checks to ensure that such an incident could not happen again. The Ombudsman considered that to be a satisfactory outcome and upheld the complaint only to the extent that the general surgeon had not ensured that Mr E's son was appropriately assessed before the referral.

Case No. W.10/99-00
The former Glan Clwyd General Hospital NHS Trust

Care and treatment of an elderly patient

Summary of case

Mr F, who had Alzheimer's disease, developed a throat condition which affected his ability to swallow. He was admitted to Glan Clwyd Hospital because he had stopped drinking completely; but he was discharged home the next day. Two days later, he was readmitted as an emergency after collapsing at home. Staff initially told Mr F's daughter that her father had suffered a stroke and had only a few hours to live. However, after suffering some dehydration, Mr F appeared to revive, although he suddenly suffered a fatal heart attack two days later. Mr F's daughter complained about the care and treatment her father received during his two admissions. The Ombudsman's investigation considered six aspects of Mr F's care during the second admission: that he was not seen by a doctor from the time he was admitted until the time he died; that he was inappropriately prescribed the drug Dothiepin; that nurses failed to attend or monitor his condition; that despite requests an intravenous drip which became dislodged was not resited; that Mr F received inadequate nourishment in that staff failed to assess and monitor adequately his nutritional and fluid intake; and, that staff failed to make accurate and contemporaneous records.

Findings

The Ombudsman found that Mr F was examined on admission, when doctors regarded his prognosis as very poor. However, he criticised the fact that despite a dramatic improvement in Mr F's condition, Mr F was not reviewed by medical staff before his death. The prescription of Dothiepin was not found to be inappropriate as medical staff were acting in good faith on the basis of erroneous information supplied by Mr F's general practitioner. The
Ombudsman also found that Mr F’s condition was inadequately monitored by nursing staff to the extent that the poor quality of nursing records called into question the adequacy of staff contact with Mr F’s relatives, and the adequacy of observations taken. There was no indication that a decision not to resite Mr F’s intravenous drip was taken by, or was discussed with, medical staff.

**Remedy**

The Trust apologised and agreed to implement a number of recommendations made by the Ombudsman, including the examination of arrangements for the review of patients by medical staff, the use of food and fluid charts, and to remind staff of the necessity of maintaining accurate and contemporaneous records.

**Case No.W.146/99-00**

**A GP in the area of Bro Taf Health Authority**

**Care and treatment by a GP**

**Summary of case**

Miss G’s father, Mr G, who suffered from senile dementia, regularly attended a day care unit. During 1997, Miss G became aware that doctors at the day care unit had prescribed Promazine, a sedative, and this was added to the list of repeat prescriptions issued by his GP, which also included a diuretic, Lasilactone. In May 1997, doctors at the day care unit replaced Mr G’s prescription of Promazine with another sedative, Thioridazine. However, when Miss G next collected a repeat prescription from the GP practice, Thioridazine had been included in addition to Promazine; a local pharmacist refused to dispense the prescription as it included too many sedatives. In December 1997, Mr G fell at home, possibly injuring his feet. His mobility deteriorated and Miss G requested a home visit from the GP’s practice. She received a telephone call from one of the practice’s GPs (the first GP). Miss G complained that the first GP had been rude and abrupt, and had unreasonably assumed her father’s problems to be a result of his dementia. Another GP (the second GP) visited her father that day, and again six days later, when he arranged for Mr G’s admission to hospital. Miss G complained that the second GP’s examinations of her father were inadequate; that he was rude and abrupt to her; and that he gave the hospital incorrect information about Mr G’s medical history, including a failure to mention Mr G’s prescription of Lasilactone.

**Findings**

The Ombudsman did not uphold the complaint. The evidence showed that, in prescribing Promazine and Thioridazine, the GP practice had acted in good faith on information contained in two conflicting discharge letters sent by the day care unit. It could have been reasonable for both drugs to be prescribed; and so the error was not immediately obvious. However, when the pharmacist queried the prescription, the error was rectified and Mr G’s prescription records were corrected. There was conflicting evidence about the attitude of the first GP during the telephone conversation. However, he did arrange for his colleague to visit and
assess Mr G, which indicated that he did not pre-judge Mr G’s condition. Miss G’s own evidence on the demeanour of the second GP during the two house calls contradicted itself; and, in the absence of any other evidence, the Ombudsman concluded that he was not rude. The second GP had taken detailed notes of his examination of Mr G and his symptoms, which supported the view that he had undertaken an appropriate examination. The information supplied by the GP to the hospital was accurate, included the fact that Mr G was taking Lasilactone; and conveyed Mr G’s past medical history in an appropriate manner.

Case No.W.84/00-01
North East Wales NHS Trust

Replacement of dentures

Summary of case

In February 1999 Mr H, who had previously found it difficult to obtain satisfactory fitting dentures from local dentists, was supplied with a new set of dentures by a consultant at Wrexham Maelor Hospital. Mr H returned regularly to the hospital for the dentures to be adjusted until July 1999, when the consultant told him that, contrary to Mr H’s own view, the dentures fitted satisfactorily and that further adjustments were not necessary. Over the months that followed, Mr H continued to suffer discomfort; and in May 2000 he attended the consultant’s clinic as a walk-in patient. The consultant agreed to replace Mr H’s dentures to alter their appearance, but explained that as they were still functioning well Mr H would need to await his turn on the waiting list. Mr H was later advised that because his dissatisfaction with the dentures was cosmetic and not functional he would need to wait about two years for them to be replaced. He considered that unsatisfactory. The Ombudsman agreed to investigate to determine whether Mr H should have been offered more urgent remedial treatment.

Findings

As part of the investigation Mr H agreed to be examined by an independent specialist in restorative dentistry. The specialist confirmed that the dentures Mr H was wearing were unsatisfactory and that he should not have to wait longer than absolutely necessary for them to be replaced. However, he said that there was considerable doubt whether the dentures he saw were in fact a matched pair. When this was put to Mr H, he explained that following the consultant’s refusal to replace his dentures quickly, he had, because of his desperation to avoid further discomfort, tried other older dentures he still had at home. He had then continued to wear the most comfortable combination. Given that information and the specialist’s comments, the Ombudsman considered it highly unlikely that the dentures Mr H was wearing when examined were those supplied by the consultant. Accordingly, he could not determine whether or not the quality and fit of the dentures supplied by the consultant at Wrexham Maelor Hospital were such that Mr H should have been offered more urgent remedial treatment. He made no finding on the complaint.
Remedy

Although the Ombudsman could not reach a finding on the complaint it was clear from the specialist's examination that Mr H's current dentures were unsatisfactory. In light of that the Trust said that their community dental services were prepared to consider a new referral for replacement dentures from Mr H's GP or dentist.

Case No.W.96/98-99
The former Llandough Hospital and Community NHS Trust
Delay in diagnosing injuries to a woman's arms and shoulders following a seizure

Summary of case
Mr J, whose wife was admitted to Llandough Hospital on 19 June 1997 following a seizure, complained that there was delay in identifying the cause of pain in both her arms and shoulders. He said that little was done to control her pain until after 23 June, when her left shoulder was x-rayed and found to be fractured; also that it took another x-ray on 24 June for a dislocation and fracture on her right shoulder and arm to be identified. He wrote to the Trust asking why his wife's complaints of pain had been ignored and why she had not been x-rayed sooner. He was dissatisfied with the Trust's response and asked the Ombudsman to investigate.

Findings
The Ombudsman found that Mrs J's doctors were principally concerned with establishing the cause of her seizure, as there was genuine concern that she might have a life-threatening brain condition. Although injury to the arms and shoulders is a recognised, but rare, complication of seizure, the Ombudsman did not believe that the medical team could have anticipated such injuries on admission as there was no significant evidence of such injury at that time. Shortly after admission a doctor noted that Mrs J appeared to have pain on moving her arm; and an x-ray was ordered. There was a delay in carrying out that x-ray, but that was mainly attributable to the need for Mrs J first to undergo tests to determine the exact nature and seriousness of her brain condition. Furthermore, the ward sister, in the exercise of her clinical judgment, decided that the planned x-ray should be deferred, as she felt that Mrs J was too unwell to be taken to the x-ray department when first called. The Ombudsman's clinical assessors considered that the staff had acted in Mrs J's best interests, and that any delay which had occurred had not compromised the success of surgery later carried out to her arms and shoulders. The Ombudsman also found that the pain relief offered to Mrs J was appropriate; and that staff used appropriate techniques to move her in order to minimise her discomfort. He did not uphold Mr J's complaints.

Case No.W.136/99-00
The former University Hospital of Wales and Llandough NHS Trust
Inappropriate marking of surgical tape following surgery

Summary of case
In November 1999 Mr and Mrs K's four-year old daughter underwent
surgery in the University Hospital of Wales to remove a malignant tumour. Previously she had been fed through a naso-gastric tube, which her parents understood needed frequent replacement - a procedure which their daughter found very distressing. Shortly before surgery Mr and Mrs K asked if the naso-gastric tube could be changed while their daughter was anaesthetised. On their daughter's return from theatre they were shocked to see written on the tape that secured the naso-gastric tube to their daughter's face; 'This tube does not need to be changed'. Mr and Mrs K complained to the Trust and were told that the marking of tapes in theatre was standard practice. Mr and Mrs K complained to the Ombudsman that in writing on the tape on their daughter's face the Trust's staff had acted in an inappropriate and distasteful manner.

Findings

Although the Ombudsman was not asked to consider whether or not the girl's naso-gastric tube should have been changed, his medical adviser pointed out that it was regrettable that the issue had not been fully discussed with her parents. Because of that, the method of communication about the tube, coming in the manner it did, and at such a stressful time for the parents, was almost certain to cause offence. The Ombudsman recognised that the marking of tapes and dressings was an important part of delivering effective and accurate health care. However, in this case, Mr and Mrs K could be forgiven for thinking that their daughter's dignity, and their feelings, had been compromised for the sake of clinical expediency. He upheld their complaint and said that they had been entitled to a more sensitive and explanatory response from the Trust.

Remedy

The Trust apologised to Mr and Mrs K. During the investigation they told the Ombudsman that they were reviewing their practice with regard to the marking of tapes and dressings. They agreed to complete that review as quickly as possible in order to disseminate a clear policy to their staff. The Trust apologised to Mr and Mrs K, and said that they were content to seek input from Mr and Mrs K to their review.

Case No.W.22/00-01
Carmarthenshire NHS Trust

The appropriateness of a convener's decision to grant an independent review

Summary of case

In October 1996 the Trust received a request for medical records from solicitors who had been instructed to consider a claim for clinical negligence from Mrs L in respect of treatment given by a consultant orthopaedic surgeon at West Wales General Hospital in July 1993. The allegations made by Mrs L were investigated by the Trust; and their solicitors outlined their findings to her solicitors in February 1997. A year later, Mrs L's solicitors advised the Trust's solicitors that they had been instructed not to proceed with the claim; and the matter was considered closed. However, Mrs L continued to correspond with the Trust,
repeatedly raising the same issues. After receiving a further letter from Mrs L in April 1999, the Trust’s chief executive met with her. Subsequently, at Mrs L’s request, the Trust’s convener decided to hold an independent review (IR) of her complaint. The consultant surgeon complained to the Ombudsman that Mrs L’s pursuit of her complaint by way of an IR constituted personal harassment in that investigation of the complaint had been completed and the findings communicated to Mrs L; litigation had been considered and not pursued; and the complaint was now time-barred, both from consideration under the NHS complaints procedure and under the statute of limitations on legal action.

Findings

The Ombudsman considered that it was clear in February 1998 that consideration of legal proceedings had ceased. The consultant surgeon believed that that demonstrated that there were no grounds for action. The Ombudsman said, however, that even if that were so, it did not follow that Mrs L did not have legitimate concerns which it was proper for her to pursue through the NHS complaints procedure. The fact that legal action had been considered did not mean that action under the complaints procedure must cease for all time; and the Trust had acted correctly when they dealt with a letter from Mrs L in December 1998 in accordance with the complaints procedure. Although Mrs L requested an IR in May 1999, the Trust did not forward that request to the convener until November 1999, because they thought they could still resolve matters locally. The Ombudsman criticised that delay, as it is a requirement of the complaints procedure that requests for IR should be passed to the convener immediately. The Ombudsman found that, when considering Mrs L’s request, the convener had considered the issues of litigation and timing. On the matter of litigation, she had been given advice by the IRP Secretariat consistent with the Ombudsman’s views. On the matter of timing, she had correctly concluded that she had discretion to waive time limits, and that whether or not the complaint was time-barred from legal action had no relevance to its consideration under the complaints procedure. The Ombudsman concluded that the convener’s decision that Mrs L had made a valid request for IR, which it was appropriate for her to consider, was fully informed and not unreasonable. He also decided that in the light of the clinical advice the convener had received, it was reasonable for her to conclude that there were issues which could only be adequately addressed by an IR. He did not uphold the complaint.

Remedy

The Trust agreed to proceed with the IR without delay. They also undertook to refer future requests for IR to the convener immediately.
Case No.W.108/99-00
A GP in the area of Gwent Health Authority
Welsh Ambulance Services NHS Trust

Inadequate care

Summary of case

Mrs M suffered from gastro-oesophageal cancer, and complained on 16 April 1998 that she had a sharp pain on breathing in. An on-call doctor visited her and concluded that her chest pains were muscular in origin; and he prescribed pain-killing tablets. Next day, one of Mrs M’s daughters, who was not satisfied that the pain was muscular, asked Mrs M’s own GP to visit. He diagnosed that she had a build-up of fluid on the lungs and arranged her admission by ambulance to hospital. Mrs M’s daughters accompanied their mother in the ambulance. Mrs M was declared dead on arrival at the hospital. Mrs M’s daughters complained that the care provided by the on-call doctor was inadequate, in particular, that by not conducting a chest examination he had not put himself in a position to make an adequate diagnosis. They complained, too, that the ambulance service had provided inadequate care whilst transporting Mrs M to hospital.

Findings

The Ombudsman’s medical assessors said that it appeared from the evidence that there was a significant change in Mrs M’s condition between the on-call doctor’s visit and her own GP’s visit. They said that such a change was medically explicable in the light of Mrs M’s clinical condition. The Ombudsman accepted the assessors’ advice that the on-call doctor had put himself in a position to make a reasonable assessment of Mrs M’s condition; and that he gave appropriate treatment. However, he criticised the adequacy of the on-call doctor’s communication with one of Mrs M’s daughters after his examination of her mother. If he had discussed his diagnosis more fully, Mrs M’s family could have understood better the reasons for his actions, and the subsequent turn of events. The Ombudsman was concerned that the doctor had failed to make a written record of his visit, contrary to NHS (General Medical Services) Regulations and General Medical council guidance. He upheld the complaint only to the limited extent of the communications failures. The Ombudsman did uphold the complaint against the ambulance service. Although it was not possible to answer all of Mrs M’s daughters questions conclusively, it was clear that their concerns had been fully considered by an independent review panel, who had found no reason to criticise the ambulance staff involved. It was unsatisfactory, however, that a patient report form detailing the care and treatment given by the ambulance crew was missing.

Remedy

The on-call doctor recognised his mistake in not making a record of his visit; and he said that he would make written reports in future. He also took the matter up with other practices in the on-call rota to ensure that whenever a patient was seen by a doctor from a different practice, a note was made of that visit and passed.
promptly to the patient's own GP. The Ambulance Trust commissioned an extensive review of the procedures operated in the completion and storage of patient report forms; and implementation of the findings of that review has led to new Wales-wide procedures to improve the previous situation.

**Case No.W.13/99-00**  
A GP practice in the area of Bro Taf Health Authority  
Bro Taf Health Authority

**Removal of a patient from a GP practice list**

**Summary of case**

On 3 July 1998 Mr N complained to the General Medical Council (GMC) about doctors at the practice with which he was registered; but on 30 September the GMC told him that they would be taking no further action. On 6 October, the practice manager wrote to Mr N and asked him to register with another doctor because he had moved out of the practice's catchment area. In response, Mr N said that the time he had spent out of the area was due entirely to his being forced to leave his property by court order, and that it was only a temporary arrangement. A doctor in the practice replied on 9 October confirming the original decision and saying that if Mr N returned to the area he could reapply to join the practice, but that he did not believe that Mr N would be allowed to rejoin their lists. On 22 October, the Health Authority wrote to Mr N confirming his removal from the practice list. Mr N complained that his removal from the GP list was unreasonable and had been made as a direct result of the complaint he made about the practice partners.

**Findings**

The Ombudsman found that the regulations and guidance were clear on the matter of removals from the lists of GPs; and that the practice partners had complied with both. The practice had known in April 1998 that Mr N was living at an address outside the practice boundary; and that was confirmed by the address given to them by the GMC in October. There were no particular reasons to keep him on their list; and, in the Ombudsman's view, the practice leaflet and Mr N's medical card both made it clear that people who move away from a practice's area may be asked to move to another practice list. The Ombudsman was satisfied that Mr N had been removed because of his change of address; and not because he had made a complaint. He found that the practice had followed an acceptable process for notifying both Mr N and the Health Authority of its intentions; but he criticised the practice for suggesting to Mr N that he would not be allowed to rejoin the practice if he returned to live in the practice area. It was not helpful to have suggested or pre-judged the outcome of a hypothetical situation. The Ombudsman also criticised the Health Authority for dealing with the matter under the wrong Regulation; but he considered that, overall, they had dealt with Mr N's concerns in a helpful and constructive manner. He did not uphold Mr N's complaints.
Remedy

The Health Authority agreed to revise its procedure and provide written guidance for its registration staff on removals from doctor’s lists.

Case No.W.88/99-00

A GP in the area of Gwent Health Authority

Failure to address a patient’s concerns regarding weight control, heart attacks and sexual abuse

Summary of case

Mrs P complained to her GP in September 1998 about his attitude in dealing with her health problems. In particular, she said that the GP was not helpful when she told him that she had been sexually abused; and that he had told her not to come to him with the problem when she asked for help to reduce and control her weight, a problem which she thought could lead to a heart attack because she had a family history of heart disease.

Dissatisfied with the GP’s response, Mrs P asked for an independent review (IR), which was held on 18 August 1999. The IR panel report was issued on 12 October; but Mrs P remained dissatisfied and complained to the Ombudsman.

Findings

Mrs P could recall only two occasions on which the subject of her need for support and advice about weight control was raised; once when she requested, and was refused, Xenical (a slimming tablet), and once when the GP ordered tests to establish if Mrs P had a thyroid condition. The GP, on the other hand, claimed that he gave dietary advice when Mrs P first registered with him; but that, except for when she requested Xenical, Mrs P never sought dietary advice from him and was not interested in changing her lifestyle. Having examined Mrs P’s medical records, the Ombudsman’s GP adviser said that the GP had carried out a comprehensive assessment of Mrs P’s problems, recognised the clinical importance of her weight, and showed continuing concern about that. He concluded that the GP had provided adequate support and advice about weight control. The Ombudsman accepted the adviser’s assessment and did not uphold the complaint. On her own admission, Mrs P had not approached the GP about the chest pain she had experienced, except on 19 May 1998, when those pains were severe. The Ombudsman’s adviser said that the evidence of the medical records was that the GP was aware of, and had due regard to, Mrs P’s risk factors for ischaemic heart disease; and that he had initiated appropriate investigations. The Ombudsman did not uphold a complaint that the GP had not addressed her fear of a heart attack. Mrs P also complained that the GP had not addressed her problem of having been sexually abused; but the GP could not recall the subject ever being raised. There was no reference to it in Mrs P’s GP records. The Ombudsman’s adviser said that if a history of sexual abuse had been reported by Mrs P, the GP would have had no reason not to refer her for expert counselling. The Ombudsman was inclined to agree with that analysis but, in the absence of any confirmatory evidence, could make no finding on that complaint.
Case No.W.93/99-00
A GP in the area of North Wales
Health Authority
North Wales Health Authority

Unreasonable response to a patient’s request for assistance, removal from the list of patients

Summary of case
On 19 November 1998 Mr Q’s wife, who suffered from multiple sclerosis, had problems with her suprapubic catheter, which became stuck in her bladder. The community nursing service said that they could do nothing because they had not been trained in the relevant procedure so the GP visited Mrs Q and sent her to hospital, where the catheter was replaced. Mrs Q was sent home, but the catheter kept becoming blocked. On 27 November, Mr and Mrs Q asked the community nurse to come and change it; but she could not, and instead telephoned the GP practice, who in turn telephoned Mr Q. Because he felt that the GP was not fully aware of Mrs Q’s history, Mr Q asked to speak to either of two GPs who had previously dealt with her; but the practice secretary said that he had to speak to the GP. When he did so, the GP said that he could not come out to change the catheter, and told Mr Q to take his wife back to the hospital. Shortly afterwards, Mr Q and his family received notice that they were being removed from the practice GPs’ lists. Mr Q complained to North Wales Health Authority that he and his family had been removed from the GPs’ lists because of the seriousness of Mrs Q’s condition and the costs involved in treating her. Mr Q was dissatisfied with the responses he received from the Health Authority and from the GP, who said that the removal had been because of the irretrievable breakdown in relationship between Mr Q and the practice. Mr Q requested an independent review (IR). On 3 March 1999 the Health Authority’s convener wrote to Mr Q that there were a number of issues which needed to be clarified and saying that an independent GP adviser would write to the GP for further information. Having heard nothing more, Mr Q contacted the convener again in September. She told him that the GP adviser had discussed the matter with the GP, and had suggested that he write to Mr Q. The convener said that, although that had not happened, there was little further positive action she could take. She refused Mr Q’s request for an IR because she did not think it would serve any constructive purpose.

Findings
The Ombudsman’s assessor advised that the GP’s clinical management of Mrs Q’s catheter problems was not unreasonable. The GP had responded promptly, recognised the limitations of his expertise, and referred appropriately to access the care and treatment that was needed. The Ombudsman found that Mr Q had expected more of the GP than it was reasonable to expect. The GP did not have the technical skill to deal with Mrs Q’s blocked suprapubic catheter. The Ombudsman’s assessor made it clear that GPs could not be expected to possess that skill. Moreover, Mr Q had assumed, incorrectly, that the GP was responsible for training community nurses to deal
with suprapubic catheters. These misconceptions had been the cause of much friction between Mr Q and the GP; and it was not unreasonable for the GP to feel that he could no longer provide GP services to the family. Because the practice operated a shared list system under which patients had to be willing to see any of the practice partners, and any of the practice partners might be called upon to make a home visit to any patient, it was agreed by all the partners, that all members of a family should be removed from the list. The Ombudsman’s assessor said that that was in line with most GPs’ practices. The Ombudsman did not uphold the complaint; but he was concerned that the GP had not informed Mr Q of the reasons for his removal until he was asked to do so by the Health Authority. He regarded that as a matter of common politeness; and the assessor said that it was modern practice to do so. The Ombudsman regarded it as wholly unsatisfactory that, having asked an independent GP to write to the GP seeking clarification of the unresolved issues, the convener did nothing more until Mr Q wrote to her again in September. She then said that she was under the impression that local resolution had reached a successful conclusion; but the Ombudsman could not see that she had any justification for forming such an impression.

**Remedy**

The GP and his practice colleagues reviewed their process for patient removal to bring it in line with current practice. The Health Authority recognised their failings and produced a revised action sheet for conveners considering requests for IR.

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**Case No.W.84/99-00**

**A GP in the area of Bro Taf Health Authority**

**Shortcomings in primary care**

**Summary of case**

Mr R was an elderly man suffering from myelodysplastic syndrome (a condition which precedes leukaemia) and multi-infarct dementia (dementia caused by a small series of strokes). On the morning of 28 July 1998, his daughter, Ms R, requested an urgent home visit by his GP as Mr R had collapsed; but it was an hour before the GP arrived. He conducted a brief examination, and before leaving commented only that Mr R was ‘fading away’; he gave the family no further information or guidance. Mr R’s condition did not improve, so at 3.00pm Ms R telephoned the surgery again. She spoke to the GP; and as a result of that conversation the GP arranged for an ambulance to take Mr R to hospital. However, when the ambulance arrived at the home, the crew had no instructions about where to take Mr R or knowledge of his condition. Mr R died on 6 August from acute myeloid leukaemia.

**Findings**

The GP explained that he had prioritised his home visit to Mr R taking account of his knowledge of Mr R’s medical history and the symptoms reported by Ms R. The Ombudsman’s clinical adviser confirmed that the delay of an hour in visiting was reasonable; and the Ombudsman accepted that view. The evidence about Mr R’s condition when the GP saw him conflicted. Ms R said that he was semi-conscious and unable to communicate;
the GP said that he was fully conscious and comfortable. The GP’s view was supported by his own record, and by the admitting doctor’s hospital record of the history given by Ms R that Mr R had collapsed, but recovered within about ten minutes. The clinical advice to the Ombudsman was that Mr R’s symptoms were consistent with multi-infarct dementia, for which there is no treatment, and that hospital admission was not required. The GP said he knew from previous contact with the family that Ms R was aware of Mr R’s condition and the prognosis. However, he apologised for his use of the phrase ‘fading away’, and accepted the Ombudsman’s view that he should have offered Ms R more information and explanation. This was the only aspect of the complaint that the Ombudsman upheld. About the arrangements for admission to hospital, the Ombudsman saw a clear referral letter written and faxed by the GP to the emergency admissions unit. The ambulance service had a record of where Mr R was to be taken. The Ombudsman was therefore satisfied with the arrangements made by the GP for Mr R’s admission to hospital.

Findings

The Ombudsman took clinical advice on the complaint. On the basis of that advice, he concluded that there had been no shortcomings in the conduct of the original surgery, and explained that incisional hernias are not an indicator of any failure in the surgery: they are a known but unpredictable complication. The investigation found written evidence that the options for the future management of Mr S’s hernia were considered earlier than he believed to be the case; and the Ombudsman concluded that Mr S’s care was satisfactory.

Case No.W.92/99-00
North Glamorgan NHS Trust
Cardiff and Vale NHS Trust
Inadequate arrangements for support after discharge

Summary of case
In March 1998, Mrs T was diagnosed as having breast cancer. The breast care nurse who worked for the first Trust (the first BCN) attended Mrs T’s out-patient consultations and visited Mrs T at home to give information and support. Mrs T opted to have surgery at
a hospital managed by the second Trust. She and the first BCN agreed that the first BCN would continue to be involved in Mrs T’s care after her discharge from hospital. While in hospital, Mrs T was seen by a breast care nurse who worked for the second Trust (the second BCN); and Mrs T told the second BCN what she had agreed with the first BCN. After Mrs T’s discharge from hospital on 26 March, she complained that she heard nothing from the first BCN until 3 April, when the first BCN told her that she was going on holiday. She heard nothing more from the first BCN until she telephoned on 5 May. Mrs T complained that she had been distressed and in need of help and support from the first BCN after her discharge.

Findings

The Ombudsman established that responsibility for the arrangements for Mrs T’s aftercare lay with the discharging hospital. However, the second BCN had spoken to the first BCN when Mrs T was discharged to confirm that the first BCN would be contacting her, although technically the responsibility remained a joint one. Mrs T was given contact numbers for the second BCN and the hospital ward. Despite Mrs T’s recollection that the first BCN did not contact her until 3 April, the first BCN recorded that she spoke to Mrs T on 27 March, the day after her discharge. Her diary showed that she was on leave each day the following week, including 3 April. On her return from leave, the first BCN recorded that she tried unsuccessfully to contact Mrs T on 6 and 9 April.

With bank holidays and more annual leave, the first BCN was largely absent from work until she telephoned Mrs T, again unsuccessfully, on 1 May, before finally speaking to Mrs T on 5 May. The first BCN said she was satisfied that Mrs T had other sources of help during that time: district nurses were visiting her at home, and she had contact numbers for the second BCN and the ward. Furthermore, she was attending another hospital for radiotherapy. The Ombudsman did not uphold the complaint, concluding that the fact that Mrs T was not seen by a BCN following her discharge was due to an unusual set of circumstances, rather than any inadequacy in arrangements. He was pleased to note that the second Trust had introduced a written information pack for breast care patients, including information about post-discharge care.

Case No.W.73/99-00

Two GPs in the area of Bro Taf Health Authority

Failure to provide adequate level of care

Summary of case

Mr U’s ex-wife, Mrs U, was a smoker with a history of high blood pressure and raised cholesterol. She attended her GP’s surgery on 30 December 1998, when she saw the first GP. Mrs U complained of intermittent chest pains and numbness in her arms and hands. The GP took Mrs U’s history, listened to her chest, and took her blood pressure before concluding that she had a viral infection. The GP prescribed aspirin. The following day, Mrs U
requested a home visit because the chest pains had become worse and she had pain in her arms. Another GP visited Mrs U. After taking a history and examining Mrs U, the second GP concluded that the pain was not cardiac, although he was not certain of its origin. He prescribed painkillers. Mrs U collapsed and died on 1 January 1999. Mr U believed that in the light of Mrs U’s history, the GPs should have referred her to hospital where an ECG and other tests could have been done.

**Findings**

It was agreed that Mrs U was a patient at risk of heart disease. However, the clinical advice given to the Ombudsman was that Mrs U’s symptoms were not typical of cardiac pain. The assessors’ view was that both GPs were aware of Mrs U’s history and increased risk of heart disease, and had explored appropriately the possibility that the pain was cardiac in its origin. The assessors emphasised that the diagnosis of heart attack in the primary care context is essentially a matter of clinical examination. Although some doctors would have arranged an ECG, they agreed that one was not indicated in Mrs U’s case as her pain was atypical and did not point to cardiac disease. The Ombudsman accepted the assessors’ advice and concluded that both GPs had exercised a reasonable standard of care. He did not uphold the complaint.

Case No.W.37/00-01

**Swansea NHS Trust**

**Loss of clinical records**

**Summary of case**

Mrs V’s brother, Mr X, died on 23 July 1999 having received in-patient treatment in Singleton and Morriston hospitals. In September 1999, Mrs V asked for her brother’s medical records; but the Trust told her that despite an extensive search, they were unable to find them, apart from a few pages of notes. The Trust wrote to Mrs V every month until March 2000 updating her about their search, after which she heard nothing more. The Ombudsman began his investigation in September 2000. Shortly afterwards, the Trust located Mr X’s records and provided them to Mrs V.

**Findings**

The Trust accepted that Mr X’s records had been lost from at least September 1999 to the start of the Ombudsman’s investigation, when they were found to have been returned to the medical records library at Singleton hospital. As Mr X had transferred from Singleton hospital to Morriston hospital, his records may have been transferred with him. However, there was no record of that on the Trust’s computer tracking system, and the Ombudsman was unable to determine exactly how or when Mr X’s records went missing. The Ombudsman considered whether there was any wider systems failure within the Trust, but concluded that there was not. The Trust demonstrated that it had clear measures in place to safeguard medical records. They had a written
policy and clearly allocated responsibilities; they had a closed library system and a computer tracking system; and they undertook regular staff training. The Trust acknowledged that it was unacceptable that the search for Mr X’s records had lapsed in March 2000 due to the departure of a member of staff. The Ombudsman upheld the complaint.

**Remedy**

The Trust apologised to Mrs V, and agreed to use this case to remind all staff of the importance of safeguarding medical records.

**Case No.W.48/99-00**

**North West Wales NHS Trust**

**Breach of confidentiality**

**Summary of case**

Since 1992, Mrs Y had been seen by a community psychiatric nurse (the CPN). Mrs Y was then referred to a clinical psychologist, with whom she had her first consultation on 7 February 1997. Mrs Y saw the psychologist frequently, and believing their discussions to be in total confidence told her that as a child she had been abused by her father. Believing other children to be at risk, as Mrs Y’s father worked with children, the psychologist reported that information to the local social services department.

Mrs Y did not believe that the psychologist had warned her of any circumstances in which she could disclose information given to her in confidence, and complained that her confidence had been breached.

**Findings**

The professional assessors appointed to advise the Ombudsman explained that although the psychologist had a duty of confidence to Mrs Y, she also had professional responsibilities for the protection of children under child protection procedures. In her evidence to the Ombudsman, Mrs Y was clear that she had not been told of any limits to confidentiality. However, both the psychologist and the CPN believed that Mrs Y was aware of the limits: the psychologist had twice documented that she had discussed the limits of confidentiality with her. Mrs Y gave the CPN specific information about two children who were alone with her father, but then told the psychologist that she did not think that other children were at risk. However, the assessors, and the Ombudsman, were satisfied that the information disclosed by Mrs Y indicated a potential risk, and that the psychologist had acted properly in passing information to the social services department. The complaint was not upheld.
ANNEX A

MARKERS OF SUCCESS - GOOD PRACTICE IN NHS COMPLAINTS MANAGEMENT

Complaints are more often dealt with successfully when NHS organisations

◊ choose an appropriate and proportionate approach to investigation
◊ involve clinicians from the outset
◊ provide training and support for staff who investigate complaints
◊ assure sound communications with patients, relatives and complaints, during and after the investigation
◊ support staff who are complained about in the course of an investigation, keeping them informed of progress and of the outcome
◊ link their work on complaints with other aspects of corporate and clinical governance
◊ include information about the complaints system in induction for all staff, including those rotating between posts and organisations

There are some practices at the convening stage of the procedure that help secure the confidence of complaints and those complained about. These include seeing that conveners

◊ are well trained and well supported by health authorities and trusts
◊ are completely familiar with the Directions that govern their work and the guidance that supports it
◊ seek appropriate clinical guidance from all clinical disciplines involved and form judgements based on that advice, rather than adopt it uncritically
◊ seek advice from a lay chair properly
◊ confine themselves to considering whether or not there should be an IRP: a convener who feels he or she has to enquire beyond the papers they receive should see this as a signal either that further local consideration is required, or that a panel is needed
◊ address all the issues raised by the complainant, even when some are referred back for further local resolution and others are referred on to a panel
◊ give full reasons for refusing a request to convene a panel. Unsupported refusals compound dissatisfaction with the system
◊ understand that the parties to the complaint may not see the convener as impartial, and conduct themselves accordingly
Independent reviews are likely to lead to more satisfactory conclusions when

◊ all the parties have a clear and common understanding of the terms of reference for the review, and address them

◊ the panel meeting is not conducted in a way that encourages an adversarial approach on anyone’s part

◊ sound judgements are made about flexibility in the way the Panel works

◊ careful consideration and planning means that all who have relevant information are interviewed or asked to contribute what they know

◊ the conclusions members reach are based on the evidence they have heard, or read and the recommendations are based, in turn, on those conclusions

◊ reports are well structured and reflect the panel’s considerations in full

◊ there is a clear understanding that the lay chair will write the report and about the responsibility for circulating it and producing the final version of the report

◊ steps are taken to be fair, and seen to be fair, to all parties
The Welsh Administration Ombudsman and Health Service Ombudsman for Wales

What he does and how to contact him

The Welsh Administration Ombudsman investigates complaints from members of the public that have suffered injustice because of maladministration by the National Assembly for Wales or certain public bodies involved in devolved affairs. He can also look at complaints that individuals have been refused information to which they are entitled under the Code of Practice on Public Access to Information adopted by the National Assembly.

The Health Service Ombudsman for Wales investigates complaints about any part of the National Health Service (NHS) in Wales, including family doctors (GPs), dentists, pharmacists or opticians providing a NHS service. Before the Ombudsman can look into the complaint, it must first be taken up locally with the hospital, clinic, surgery, NHS Trust or Health Authority concerned.

His service is:

- Completely independent
- Confidential
- Free of charge

For further information and an explanatory leaflet please contact:

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