The Ombudsman's Casebook

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Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

A word from the Ombudsman

I'm taking the opportunity in writing this introduction to focus on complaints that do not come to my office to highlight some anomalies in the access to independent redress. Recent publicity regarding faulty breast implants has highlighted the lack of recourse for patients accessing private health care. My jurisdiction enables me to consider treatment by private health providers when it is commissioned by the NHS, although this is a relatively small part of my work and, unlike the position in England, is highly unlikely to grow in the short term. However, wholly private healthcare is a small, but significant sector in Wales, and while it is regulated, there is no access to independent redress for its patients.

The issue of access to redress for people paying for their own health or social care services or receiving them from independent sector bodies has arisen in the course of my work. A particular example which featured in Casebook number 4 arose in the case of a hospice, which while receiving some grant aid from the NHS in Wales, raised the majority of its income through charitable fundraising. While I was able to comment on the involvement of the regulator, HIW, the majority of the complaint was outside of my remit. The desire to offer independent consideration of complaints for patients and their families in such settings has prompted the Welsh Government to propose extending my remit to cover hospice care in the future. I welcome this commitment, but would also want to say that I expect complaints to my office from this sector to be few and far between, because of the high standards of care and commitment to patients which characterise its work.

(Continued overleaf)

The Government has also proposed extending my remit to cover self-funded residents in private care homes who cannot complain to my office, while residents whose care is funded by local authorities can. A further extension to cover all private healthcare is certainly worth considering.

There is already access to statutory ombudsman schemes in some wholly private industries. The Financial Ombudsman Service is an excellent example of this. However, in these instances, it is the bodies in jurisdiction, e.g. banks and building societies, which pay for the cost of the ombudsman service. I believe there is a very strong case for private health providers also being required to give access to an ombudsman service when they themselves fail to resolve complaints. However, I am of the view that the companies concerned, and not the taxpayer, should meet this cost. This does not mean that new services should be set up for this purpose. Rather, in Wales, it would be most appropriate for complainants to have access to my office, but there will be a need for new mechanisms to be put in place through legislation in order for this to happen. Nonetheless, in a field as important as healthcare, it is essential that service users have access to free, independent and objective consideration of their complaints.

Peter Tyndall
Ombudsman

Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

Lessons Learnt

Health - Removal of patients from treatment lists

Although complaints relating to the removal of patients from GP's Practice treatment lists are less common than some other types of complaint, the finality of the decision is such that there is a reasonable chance a complaint will be submitted to this office. It is therefore essential that the decision is made in line with relevant regulations and guidance, as well as being communicated to the patient in an appropriate manner.

We have investigated a number of complaints regarding the removal of patients from lists during the last quarter. The reports issued in relation to these complaints raised concerns over the manner in which the decisions were made, specifically in relation to compliance with the appropriate regulations, which set out the steps to be taken if a GP has "reasonable grounds" for wishing to remove a patient from the treatment list.

In case 201001558, an irretrievable breakdown in the therapeutic relationship between patient and practice was cited as grounds for the removal of the patient. Whilst the report concluded that the Practice had not acted unreasonably in judging the relationship to have broken down, the report also highlighted a number of procedural deficiencies in the Practice's approach, including a failure to issue a properly-constituted warning letter; a failure to demonstrate consideration of alternative options; and a failure to provide clear reasons for removing a patient from the list.

A second case (201001972) identified other failings, including a lack of records to justify the decision to remove the patient, the date of that decision, or the advice obtained by the Practice in making the decision. There were also no recorded details as to why the Practice did not issue the patient with a 'warning' letter. This case also raised concerns over the forwarding of the complainant's complaint records to the Health Board at the same time as their clinical records. As stated in the investigation report, "patients should have no fear that there might be adverse consequences for themselves or their families because they have made a complaint..."

In view of the above cases, it is therefore a good time for GP Practices to consider their processes to ensure that they act appropriately should it ever be necessary for them to consider removing a patient from their treatment list.

Key Questions:
Are we familiar with the regulations governing the removal of patients from treatment lists?

Do we have reasonable grounds for the removal of the patient and can we evidence our decision?

Have we communicated our decision to the complainant in a clear and appropriate manner?

Health - Inadequate assessments

There have been a number of reports issued during the last quarter which have highlighted examples of inadequate examinations having been carried out. The first two examples concern inadequate assessment of symptoms, including apparent failures to adequately consider medical histories when diagnosing symptoms. The third case concerns a lack of adequate or proper nursing assessments, both at admissions and throughout the patient's stay at hospital.

In the first case (201100169), a Rapid Response Paramedic was found to have carried out an inadequate examination of a patient's condition which included a failure to identify the patient as being at particular risk, given their pre-existing condition. The unreasonable diagnosis at which the paramedic did arrive was itself also not adequately supported by the evidence available in the paramedic's paperwork.

In reference to the second case (201002020), despite the patient's history of specific ailments and their presentation at an Accident and Emergency department (A&E) for quite specific reasons, an A&E doctor failed to carry out an adequate examination of the patient and treated the symptoms with Ibuprofen. One of the report recommendations stated that the Health Board should remind staff of the importance of ensuring thorough examinations are carried out into the cause of symptoms.

The third case (201100251) highlighted fundamental inadequacies in nursing care, including a failure to adequately identify a patient's needs in respect of assistance with washing themselves or take positive action when the patient refused assistance.

When attending a surgery, A& E, or whilst staying in Hospital, patients are entitled to expect an adequate and thorough consideration of their symptoms which also takes account of any previous medical conditions which may be relevant. Whilst this does not mean that it will always be possible to arrive at the correct diagnosis, an inadequate examination will make diagnosis and subsequent treatment harder, and therefore increase the likelihood that the patient will receive a standard of care below that which they could and should reasonably expect.

Key Questions:
Have we considered the patient's medical history and pre-existing conditions when arriving at the initial diagnosis?

Have we adequately recorded the information used in arriving at the diagnosis?

Does the information support the diagnosis?

Have we carried out a thorough assessment of the patient's care requirements, including action to take in the event the patient refuses assistance?

Education - Special Educational Needs (SEN)

This office has also received a number of complaints during the last quarter that Local Educational Authorities (LEAs) had failed in some aspects of their obligation to make provision for a child's special educational needs. Further investigation of these complaints highlighted examples of failures to make provision in accordance with an SEN statement, as well as poor administration of complaints.

The report issued in relation to case reference 201001284 concluded that the LEA had failed to meet a provision in the SEN statement to carry out an adequate risk assessment. The Council had also delayed in responding to the complaint and had therefore failed to follow its own complaints procedure. The report recommended the council should ensure the wording of statements make clear who should co-ordinate specific activities in the statement. It was also recommended that the Council should review its processes for dealing with Education complaints.

The second case (201002501) raised significant concerns over the Council's poor administration and communication with the complainant. The investigation identified examples of poor practice, including a failure to record key information, which had led to confusion. Although the complaint about the failure to provide education was not actually upheld, the report recommended that in view of the confusion, the Council should still offer an apology and redress payment in recognition of the complainant's time and trouble in pursing the complaint.

The aspects of SEN complaints which this office can investigate are set out in the appropriate Factsheet here. Such investigations will also consider the standard of case administration and complaint-handling demonstrated by the LEA . As illustrated by case reference 201002501, a poor standard of case administration or complaint-handling could still result in recommendations being made by this office, even if the LEA has complied with their SEN obligations.

As well as meeting their obligations in respect of SEN, LEAs should ensure an appropriate standard of record-keeping as well as issuing prompt responses to queries or complaints. This lesson is also equally applicable to other public service providers engaged in the delivery of different public services.

Key Questions:
Have we made provision in accordance with the SEN statement?

Have we avoided delay in making such provision?

Is our record-keeping adequate and could we rely on it when explaining our actions?

Case Summaries

Health Summaries

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

October 2011 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board
Mrs W complained about the care and treatment her husband, Mr W, received whilst a patient at Ysbyty Gwynedd (the Hospital). Mr W had been admitted to the Hospital for treatment due to dysphagia (swallowing difficulties) experienced when eating and drinking. He was discharged but was readmitted four days later due to worsening dysphagia. Mrs W complained that there was a very poor standard of care provided to her husband during his admissions which led to deterioration in his condition and, ultimately, contributed to his death.

Mrs W complained about the following:

- that a procedure to stretch Mr W's gullet did not go ahead as planned due to a nursing staff error;
- that her husband was discharged without having this surgery and once readmitted, due to his declining health, he was too weak to have the procedure carried out;
- that there was a delay in obtaining a second opinion on her husband's condition and arranging a transfer to a specialist hospital.

The Ombudsman upheld the majority of Mrs W's complaints. The Ombudsman found that the clinical care provided to Mr W was inadequate as it was insufficiently intensive and lacked input from his consultant physician. The Ombudsman found that there were a number of clinical failings which contributed to the health problems that emerged during Mr W's readmission. The most significant of these was the decision to discharge Mr W from the Hospital's care without carrying out an oesophageal dilatation (a procedure to stretch the gullet) and the delay in raising its concerns regarding Mr W's deteriorating condition with a specialist hospital. The Ombudsman found that whilst the errors identified were significant, there was no definitive evidence to conclude that the ultimate tragic outcome could have been avoided but for those errors. Finally, the Ombudsman found that in general, the nursing care and management of Mr W was reasonable. However, inadequacies in some of the nursing records prevented a definitive conclusion from being reached in respect of the adequacy of care delivered when the tubing attached to his chest drain became disconnected.

The Ombudsman recommended that the Health Board should reflect on the failings in the care identified and provide confirmation of the further action taken to address the inadequacies in its staff awareness of national guidelines in relation to oesophageal dilatation, the Hospital's transfer procedures for critically ill patients, the availability of medical cover over Bank Holiday weekend

periods and the insertion of chest drains. The Ombudsman recommended that a payment of £500 be provided to Mrs W in recognition of the time and trouble in pursuing her complaint together with a full apology for the shortcomings in the care provided to Mr W and for the Health Board's failure to recognise these failings sooner.
Case reference 201001167

Other Reports - Upheld

December 2011 – Clinical treatment in hospital – Cardiff and Vale University Health Board

Mrs A's main complaint was that she was in much more pain since a procedure to remove varicose veins had been performed. She also complained that the procedure carried out differed from what she had been told would happen. In particular, although the varicose veins in her legs had been removed, the vulval varices (varicose veins in the groin area) had not. Mrs A felt that the failure to do this was a contributory factor in her increased pain.

Clinical advice was sought from the Ombudsman's clinical adviser. On the basis of the evidence considered, the Ombudsman concluded that whilst it could not be discounted that a small element of Mrs A's post operative pain might be due to the presence of vulval varices, a much more likely cause of Mrs A's pain was damage to the nerves which can sometimes occur as a result of surgery.

The Ombudsman's investigation also found that communication within the Health Board was not as effective as it should have been. This was compounded by inadequacies in clinical record keeping and the way that the Health Board dealt with Mrs A's complaints.

The Ombudsman recommended that the Health Board should:

- offer Mrs A redress of £250 in recognition of the inadequacies in the Health Board's complaints handling which had caused uncertainty and inconvenience to her; and,
- detail the measures it intended to take to address the shortcomings identified in the report. It should then communicate the steps to be taken to both this office and the complainant.

Case reference 201001985

December 2011 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board

Mrs B complained about the care and treatment provided to her daughter by the Paediatric, A&E and the Ear Nose and Throat (ENT) Departments at Wrexham Maelor Hospital. Her complaint issues included a failure by the Hospital to diagnose and treat her daughter with antibiotics for an ear infection and a failure to diagnose a long standing hydrocephalus. Mrs B also complained about the Health Board's delay in responding to her complaint and the failure to communicate information pertinent to her complaint to her.

The Ombudsman's investigation concluded that there were shortcomings in the care provided to Mrs B's daughter by the A&E and Paediatric Department. He found that the A&E doctor's examination of Mrs B's daughter was inadequate and therefore a subsequent decision to treat Mrs B's daughter with Ibuprofen was not reasonable. Again, the failure by the Paediatric Department to examine Mrs B's daughter meant that it was impossible to conclude whether or not her daughter's hydrocephalus was longstanding. Mrs B's complaints were therefore upheld. The Ombudsman did not uphold Mrs B's complaint about the ENT Department as he concluded that the treatment provided was reasonable.

Finally, the Ombudsman found that there were inadequacies in the way the Health Board dealt with Mrs B's complaints. Amongst the recommendations the Ombudsman made were that the Health Board offer Mrs B redress in the form of a written apology for the shortcomings in her daughter's treatment identified in the report. The Ombudsman also recommended a payment of £250 in recognition of the time and effort Mrs B had expended in pursuing her complaint.
Case reference 201002020

November 2011 – Clinical treatment in hospital – GP in Aneurin Bevan Health Board area
Mrs N complained about the standard of care and treatment offered by Dr X, a GP in the Aneurin Bevan Health Board area, to her mother, Mrs K, who passed away on 28 April 2009. In particular Mrs N complained that Mrs K's blood sugar levels had been "see-sawing" and that the oral medication that had been prescribed had not been successful in controlling her diabetes. Mrs N also complained that on 7 November 2008 Dr X failed to recommend Mrs K to the hospital or to the Stroke Specialist for admission following her Transient Ischaemic Attack ("TIA").

With respect to the first part of Mrs N's complaint, having considered the information available it was concluded that the treatment of Mrs K's Diabetes was reasonable and that an alternative therapy would not have led to any improved clinical impact. The target level suggesting best control for a person with Diabetes is an HbA1c level between 6.5 – 7%, and it was clear from Mrs K's records that her results were within that range. This element of the complaint was not upheld.

With respect to the rest of the complaint, it was found that on the balance of probabilities, Dr X intended to refer Mrs K as recommended by the NICE guidelines and that he failed to carry out that action. However, it was unlikely that this failure affected the final tragic outcome for Mrs K, particularly as the referral would not have resulted in an investigation of her heart's blood vessels. It was also noted that Dr X accepted that he had not referred Mrs K following her TIA and he not only apologised for this failure in his letter to Mrs N dated 12 May 2010, he also apologised for the lack of clarity on the matter when discussing this point with her. Dr X also recognised a failing in the Surgery's practice for making such referrals, and has since taken steps to introduce a protocol to try and secure the referral process in future. This element of the complaint was partly upheld.

It was recommended that the Practice Manager make herself available to discuss the Surgery's referral protocol, and its impact with Mrs N, should she wish to take advantage of such an opportunity. Dr X has agreed to implement this recommendation and has also offered to discuss any clinical aspects of the complaint, particularly Diabetes management, with Mrs N should she feel that it would be helpful.
Case reference 201001880

November 2011 – Clinical treatment outside hospital - GP in Cwm Taf Health Board area
Mrs J complained that the care and treatment provided to her mother, Mrs T, during her consultation on 5 May 2010 was inadequate and resulted in her admission to the A&E department at Royal Glamorgan Hospital on 7 May after she was found collapsed at her home. Mrs J complained that the GP failed to carry out a thorough examination and to provide an appropriate level of care to her mother in light of her mental health condition (vascular dementia), her age and due to the fact that she lives alone. She also complained about the GP's delay in replying to her initial complaint despite the involvement of Cwm Taf Local Health Board.

The Ombudsman partly upheld the complaint. Having sought clinical advice, the investigation found that the GP had provided an adequate level of care and treatment to Mrs T during her consultation. The investigation found that a formal diagnosis of vascular dementia had not been made and there was no evidence of any behaviour during her consultation which would have indicated to the GP that Mrs T was particularly vulnerable or that a more pro-active approach to her care was required. However, the investigation found some inadequacies in record keeping and the practice's complaints handling procedure.

The Ombudsman recommended that the GP provide a full apology to Mrs J for the delay in responding to her initial complaint and the failure to address the issue about whether he regarded her mother as especially vulnerable and/or mentally competent at that time. The Ombudsman recommended that refresher training sessions on the practice's complaints handling procedure should be provided to all staff members in order to address the failings identified by the investigation. The Ombudsman also recommended that the practice should carry out an audit of its records, with feedback to all GPs at the practice, to ensure that proper clinical records of all consultations are kept in line with GMC guidelines.
Case reference 201002267

November 2011 – Other – GP in Cardiff and Vale University Health Board area
Ms A complained that she had been victimised and discriminated against as she had been off listed by the Medical Practice. Ms A believed that this off listing had occurred as a result of her making complaints about not receiving appropriate care and treatment for her condition of gender dysphoria.

The Ombudsman found that the Medical Practice did not satisfactorily comply with the relevant regulations and professional guidance on the removal of patients from GP lists and he had concerns about the approach taken. This included shortcomings in the warning process, limited attempts to identify alternative solutions and a lack of clarity around the reasons for removal. He highlighted

that the Practice had given the impression that Ms A's complaints were the reason for the off listing rather than the fact that there had been an irretrievable breakdown in the therapeutic relationship which was the reason given in the removal letter. The Ombudsman also found that the off listing policy in place at the Medical Practice did not address irretrievable breakdowns in the therapeutic relationship.

The Ombudsman did however identify that the Practice had sought to progress Ms A on the relevant clinical pathway and did not find evidence of victimisation or discrimination. Having taken account of clinical advice, he was concerned about the Practice's shortcomings in its procedures and approach; however, he did not consider it unreasonable for the Practice to have concluded that the relationship had broken down in the circumstances and to have off listed Ms A.

In light of the above, the Ombudsman partially upheld the complaint. He recommended that the Practice should apologise to Ms A and clearly explain its reasons for off listing and should review its current off listing policy to ensure it complies with the relevant regulations and professional guidance and covers circumstances of irretrievable breakdown in the therapeutic relationship.
Case reference 201001558

November 2011 – Other – Cardiff and Vale University Local Health Board & Welsh Health Specialised Services Committee
Ms A was diagnosed as having Gender Dysphoria. At the end of 2006 Ms A "transitioned" and started to live and present herself as a woman. Ms A began hormone treatment as a private patient. Ms A also planned to have surgery carried out privately but by early 2010 she opted for NHS funding for her treatment and surgery as this became an option and was more appropriate to her circumstances at that time.

The local Consultant Psychiatrist made a funding application in April 2010 for treatment for Ms A as required under the Gender Dysphoria Commissioning Policy operated by Welsh Health Specialised Services Committee (WHSSC).

On 18 June 2010 Ms A's application was considered by a Panel of Advisers to WHSSC who assess applications for appropriateness and robustness. Ms A's application was declined with a request for more information and a second opinion. On 9 September a further Panel decision was made and it was agreed to proceed with the application with a request for further information from Ms A's private doctor. Ms A did not consent to this request and an 'exceptional decision' was then made by WHSSC on 16 September for onward referral.

Ms A's complaint was against both Cardiff and Vale University Health Board and WHSSC. She complained that the refusal / delay in funding her treatment for gender dysphoria was not in line with the existing Commissioning Policy. The Ombudsman partially upheld this complaint as the Commissioning Policy was unclear but he considered that the WHSSC Panel were justified in requesting further information and this was provided for in the Policy.

Ms A also complained that there had been a failure to correctly investigate her complaint about the administration of hormone treatment and Ms A referred to a lack of clarity in responsibility for prescribing hormone medication on the NHS pathway. Ms A had to pay privately for her hormone medication. The Ombudsman found that there was a failure to respond to Ms A's concern and request for a continuation of her hormone treatment on the NHS and Ms A was treated as if she was presenting for the first time. The Ombudsman upheld this aspect of the complaint.

Ms A also complained about a staff member / team at WHSSC and she believed the complaint had not been addressed by WHSSC. The Ombudsman did not uphold this element as the complaint had in fact been investigated. WHSSC was however invited to review its complaints procedure to ensure that its role and responsibilities were clearly identified and communicated.

The Ombudsman recommended that WHSSC and the Health Board apologise to Ms A for the distress caused by the ambiguity of the Commissioning Policy and for the failure to adequately address her hormone treatment. He also recommended that WHSSC reviewed and developed the Commissioning Policy for Gender Dysphoria so that it is fit for purpose. Finally he recommended that the Health Board / WHSSC provide a redress payment to Ms A for the relevant hormone treatment that she purchased privately during 2010 and a payment of £350 for the time and effort incurred in making the complaint.
Case reference 201001675 & 201001974

November 2011 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board
Dr A complained about the shortcomings in the care and treatment which he received at Wrexham Maelor Hospital following an elective hernia repair on 31 October 2008. Firstly, he complained that there was a failure to diagnose his condition whilst he was in hospital and a failure to provide the appropriate response. Dr A was concerned that he may have received an unnecessary blood transfusion and that there was a delay in diagnosing that he had suffered a heart attack. Secondly, Dr A complained that the Consultant Surgeon had refused to provide an explanation to him about his condition and the treatment provided. Finally, Dr A complained that there was a failure by the Betsi Cadwaladr University Health Board to provide a full and satisfactory response to his complaint.

Dr A's complaint was the subject of two Independent Reviews prior to the Ombudsman considering his case.

The Ombudsman upheld each element of Dr A's complaint and recommended that the Health Board should apologise to Dr A for its shortcomings and confirm the learning it has taken on board from the clinical issues raised as part of the complaint. He also recommended that the Health Board should ensure that it had clear processes in place to allow patients to raise concerns promptly when necessary and that there are mechanisms in place to monitor the quality of complaint responses. Finally, he recommended a redress payment of £350 for the time and trouble that Dr A was put to in pursuing his complaint.
Case reference 201002067

November 2011 – Clinical treatment in hospital – Cwm Taf Health Board
Mrs P had knee surgery in October 2008. The initial diagnosis was degeneration, but no tear, of the meniscus (knee cartilage). However, the operation notes show that a tear was present and was repaired. Mrs P complained about the surgery and that at subsequent outpatient appointments, her concerns about continued pain and swelling in the knee were not addressed. In August 2009, she saw a different orthopaedic consultant on a private basis and a further tear to the meniscus was identified and treated.

Having taken account of independent clinical advice, the Ombudsman concluded that there were no failings in the initial surgery. A great source of confusion around the initial surgery was that, in responding to Mrs P's complaints, the consultant orthopaedic surgeon had commented that there was no meniscal tear. This was simply wrong and suggested that the consultant had not properly reviewed the notes before responding.

It was difficult to marry up the differing accounts of the subsequent outpatient appointments, as the clinicians recorded that Mrs P was recovering well. The final outpatient appointment was in August 2009; the doctor who saw Mrs P did not examine her knee. The Ombudsman concluded that he should have done so, and it was possible that the meniscal tear diagnosed shortly after was present at that consultation.

The Ombudsman partially upheld Mrs P's complaints. He recommended that the consultant orthopaedic surgeon review the conduct of the appointment in August 2009, and be reminded of the need for care and accuracy in responding to complaints. The Ombudsman asked the Health Board to apologise to Mrs P and pay her £200 for her time and trouble in pursuing the complaint.
Case reference 201002461

November 2011 – Clinical treatment outside hospital – Welsh Ambulance Service NHS Trust
Mrs D complained that a rapid response paramedic called to attend to her husband failed to properly diagnose that his symptoms were suggestive of a significant chest-related illness and incorrectly diagnosed a gastrointestinal upset. Mrs D also complained that the paramedic stood down the ambulance which had intended to transport her husband to hospital and that the paramedic took the decision that Mr D should not attend hospital. Mrs D said that her husband's admission to hospital, with pneumonia and an abscess on his lung, the following day was proof of the misdiagnosis. Mrs D complained that the delay in admission to hospital adversely impacted upon her husband's condition and resulted in a prolonged period of treatment. Mrs D was also unhappy with the length of time taken to respond to her complaint once it had been submitted to the Trust.

The investigation found that although it was not possible to satisfactorily determine whether the paramedic decided that hospital treatment was unnecessary or if Mr D simply declined to attend, there was an absence of a proper record of this decision. The Ombudsman's clinical advisers said that the standard of examination and assessment carried out by the rapid response paramedic was inadequate. The Ombudsman concluded that this failing resulted in an unreasonable diagnosis of a gastrointestinal upset and also in a failure to identify that Mr D was suffering from a significant, chest related illness, which required further investigation in hospital.

Whilst the Ombudsman concluded that the delay in admission would have had some impact on the severity and duration of Mr D's illness, it was not possible to quantify this as Mr D had pre-existing conditions which rendered him a high risk patient, even if the delay had not occurred.

The Ombudsman recommended that the Trust should apologise to Mrs D, should review the clinical failings identified and consider the provision of additional training for the paramedic. The Ombudsman also recommended that the Trust should review its handling of Mrs D's complaint and take action to improve both the timeliness and quality of its complaint investigations.
Case reference 201100169

November 2011 – Clinical treatment outside hospital – GP in Betsi Cadwaladr University Health Board area & Betsi Cadwaladr University Health Board
Mrs M complained that her late husband's GP placed an unreasonable emphasis on his previous history of alcohol consumption when treating him and therefore failed to diagnose that his liver problems were not alcohol related, but were in fact due to cancer. Mrs M also complained that her husband was subsequently poorly cared for in hospital (particularly in respect of personal hygiene) and was discharged when it was clinically unsafe to do so and without a firm diagnosis. Mrs M complained that the GP practice failed to properly file the hospital discharge letter, which meant that the GP was unaware that the hospital suspected extensive cancer and therefore failed to treat Mr M accordingly.

The Ombudsman found that the GPs assessment of Mr M and the initial diagnosis of an alcohol related liver complaint was reasonable, given his symptoms and clinical history. The Ombudsman upheld the complaint about the failure to properly administer the hospital discharge letter and found that this failing led to an absence of early palliative care for Mr M.

The Ombudsman found that Mr M's hospital treatment was, in the main, reasonable, although he did find some failings. The Ombudsman found that there was a failure to assess Mr M's needs in a detailed and comprehensive manner and that this led to a lack of recognition of his need for assistance in attending to his personal hygiene. The Ombudsman also considered that communication with Mr M in respect of his likely poor prognosis was inadequate.

The Ombudsman recommended that each authority should apologise for the failings identified. He also recommended that the Health Board should include this case in an external review it had commissioned into recurring themes of service failure.
Case reference 201100251 & 201100252

October 2011 – Patient list issues – GP in Betsi Cadwaladr University Health Board area
Mr A complained that he had been unfairly removed from the patient list by two GPs ("the Partners") at a Surgery in the Betsi Cadwaladr University Health Board area. Mr A said that the decision to remove him was unreasonable and had been taken because he made a complaint about the Partners' service. Mr A also complained that he had been unable to register with another GP since being removed because his patient records contained false information about his conduct that he had not been given an opportunity to contest.

The investigation found that the Partners had failed to respond to Mr A's written complaints about their service in accordance with their Complaints Procedure. In addition, his removal from the patient list was not handled in accordance with the relevant Regulations or guidance as the Partners failed to issue Mr A with a written warning prior to removing him and failed to record the reasons for their decision. The Ombudsman concluded that Mr A's removal from the patient list may have been avoided or postponed and the complaint was upheld.

The Ombudsman did not uphold the complaint about Mr A's patient records. He found that the Partners had acted reasonably in response to the third party information they had received about him. However he did invite the Partners to attach a note to the records setting out his disagreement.

The Partners agreed to apologise to Mr A and to make him a redress payment of £500 in recognition of the failings indentified. The Partners also agreed to review and provide training to staff on their Complaints Procedure and Removal Policy.
Case reference 201001972

October 2011 – Clinical treatment in hospital – Cardiff and Vale University Health Board
Mrs C complained about the care and treatment that she received as a patient at a gynaecology clinic in 2009 and 2010. Mrs C complained that the registrar and gynaecologist at the clinic failed to carry out a thorough examination, correctly diagnose the cause of her symptoms and recommend appropriate treatment. Mrs C also complained about the delay in receiving a second opinion on her condition and was concerned that this delay in commencing treatment impacted on the severity of her condition and increased the likelihood of future surgery.

The Ombudsman partly upheld the complaint. Having sought clinical advice, the investigation found that the clinical assessment carried out was inadequate. However, there was no evidence that had a physical examination been undertaken, it would have lead to an earlier diagnosis of Mrs C's condition. Although the investigation found that there was an unreasonable delay in the referral for a second gynaecology opinion, the evidence confirmed that a correct diagnosis of Mrs C's symptoms had been made, that the treatments recommended were appropriate and that if the original treatment plan had been followed by Mrs C this might have resulted in the resolution of her symptoms.
Case reference 201002051

Other Reports - Not Upheld

December 2011 – Medical records/Standards of record-keeping – GP in Aneurin Bevan Health Board area
Ms C complained about the accuracy of records maintained by the GP practice. The practice recorded that she had seen GP 'A' on 20 November 2009 about a breast lump and GP 'B' on 28 January 2010 about a bowel problem. Ms C said she had not attended the practice or seen any doctor on 20 November, and that she had raised her concerns over a breast lump with GP 'A' on 28 January 2010. Ms C attended the surgery again on 9 February 2011, when a breast lump was

noted. She was referred to hospital where, the same month, she was diagnosed with an aggressive tumour. Ms C was certain in her recollections, and argued that she would not have waited from November 2009 to February 2010 – as the practice claimed - with a breast lump that was of concern to her.

The GP practice provided a computerised audit trail showing that the records had been made on the days in question and had not been changed retrospectively. The Ombudsman therefore concluded that there had been no falsification or retrospective amendment of records. However, he was unfortunately unable to make a finding regarding the accuracy of the records given the sustained and significant discrepancies between the parties.
Case reference 201100180

December 2011 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board
Mrs A complained about post-operative complications she experienced following a trans-vaginal tape procedure which she had undergone for stress incontinence in July 2008. She also complained about some aspects of her care following the procedure, including the pain she suffered on the insertion of a suprapubic catheter.

Whilst sympathising with Mrs A, the Ombudsman concluded that the procedure had been carried out with reasonable care, and that the problems which Mrs A was experiencing were a recognised, although rare, complication of the procedure. He did not uphold the complaint.
Case reference 201100147

December 2011 – Clinical treatment outside hospital – Cwm Taf Health Board
Mrs B complained about the care and treatment that her late husband Mr B received following his admission to Prince Charles Hospital on 18 July 2010 and at his subsequent follow up appointment on 24 August 2010 at the Cardiology clinic, Aberdare Hospital.

Mr B went into hospital as an acute admission and was diagnosed with right sided pneumonia and atrial fibrillation. Following treatment with medication his condition improved and he was discharged home the following week. The Health Board considered that Mr B's atrial fibrillation was probably brought on by a chest infection. It was thought that his heart rhythm could revert back to normal of its own accord but in case this did not happen, arrangements were made for him to be reviewed at outpatients and have an elective cardioversion following his discharge if needed.

Mrs B subsequently complained that there was a delay in Mr B receiving cardioversion and that he did not receive an echocardiogram whilst he was an inpatient. The Ombudsman found that it was reasonable to wait and see if Mr B's heart reverted spontaneously to normal rhythm and he did not uphold the complaint that there had been a delay in receiving this procedure. He also did not think that an earlier echocardiogram would have been significant in the overall management of Mr B's condition.

At the outpatient follow up appointment, Mrs B said that her husband was very unwell and she complained that he should have been admitted to hospital that day as on the next day Mr B suffered heart problems and sadly died. The Ombudsman did not uphold this complaint. He found that Mr B was adequately examined at the Cardiology clinic, that there were no signs of heart failure and the treatment recommended was reasonable and there was a planned review in place for the following week.

Although not clinically significant in Mr B's case, the Ombudsman did however invite the Health Board to generally review its practices to ensure that it has provision in place for urgently needed treatment to be provided at the time of an out-patient visit.
Case reference 201001835

December 2011 – Clinical treatment outside hospital - GP in Hywel Dda Health Board area
Mrs D complained on behalf of her husband, Mr D, about a failure by the practice to diagnose a spinal lymphoma. Mrs D was particularly concerned that she and Mr D had not been advised of the availability of an MRI scan; she said that had they known that it was available, they would have had the scan done straight away limiting the effects of the lymphoma. Mrs D was also concerned that Mr D provided a description of a 'balloon full of water wobbling in his lower back' during an appointment but this was not appropriately considered by the practice.

The Ombudsman did not uphold the complaint. He took the view that all necessary and appropriate tests were carried out by the practice. The tests were conducted in a timely manner and were appropriately recorded; it would not have been appropriate to have carried an MRI scan before the 'red flag' symptoms presented.

Whilst there was no record of Mr D providing the description of a 'balloon full of water' during an appointment, the Ombudsman took the view that the description would have been unlikely to have been helpful in reaching a diagnosis in any event.
Case reference 201002825

October 2011 – Clinical treatment outside hospital - Dentist in Betsi Cadwaladr University Health Board area
Mr C complained that, despite his repeated complaints of a sore tongue and sore throat, his dentist (Dr K) failed to conduct a proper examination of his tongue and soft tissues when he visited him on three occasions between April and May 2010. Mr C visited his dentist again in June 2010 with similar complaints, his dentist conducted an examination of the mouth and throat and an urgent referral was made to the hospital. Investigations undertaken by the hospital revealed a squamous cell carcinoma. As a consequence Mr C received surgical treatment to remove the tumour. Mr C also complained that a greater level of care should have been provided by his dentist given that he had been referred to the hospital in 1999 with possible signs of oral cancer, although no abnormalities were detected at that time. Dr K disputes that any complaints were made to him during the period and that when the soft tissues were examined no abnormalities were detected. Dr K states that an appropriate level of examination was undertaken during this period.

As part of the Ombudsman's investigation advice was obtained from an experienced dental practitioner who advised that the dental notes held for Mr C reflected the information provided by Dr K. The Ombudsman concluded that in the absence of independent corroboration it would impossible to ascertain whether any complaints were made to Dr K as suggested by Mr C. The adviser also confirmed that the investigations and treatment carried out by Dr K were in accordance with usual practice and reasonable in the circumstances. The Ombudsman concluded that the standard of service received from Dr K during the relevant period was not below that which would reasonably be expected of an NHS Dentist and did not uphold Mr C's complaints.
Case reference 201100195

October 2011 – Clinical treatment in hospital – Cardiff and Vale University Health Board
Mrs H complained on behalf of her son, Mr A, that when he attended the Emergency Department at the University Hospital of Wales, Cardiff, he was sent home after being assessed by a triage nurse. Mr A was admitted to hospital later the same day after being seen by an out of hours GP, and was subsequently diagnosed with severe ulcerative colitis.

The Ombudsman found that it was reasonable for the triage nurse to have sent Mr A home as, although he was unwell, his symptoms were not such as to require an emergency admission. In addition, Mr A had a pre-arranged out of hours GP appointment later that afternoon, and it was reasonable in the circumstances for the triage nurse to have advised him to attend that appointment. The Ombudsman did not uphold Mrs H's complaint, but he did make some observations about the standard of the triage records, which the Health Board agreed to share with the triage nurse.
Case reference 201100212

Benefits Administration Summaries

Upheld

December 2011 – Housing Benefit – Isle of Anglesey County Council
Mr G complained that the Council had failed to administer his housing benefit claims correctly and that this had resulted in information provided by him not being properly considered. He said that as a result, there was an overpayment of benefit that the Council was seeking to recover. He said that the Council had failed to communicate with him adequately on these matters.

Given the level of information provided, Mr G was advised that a limited investigation would take place, focussing on the manner in which the Council had dealt with its decision on the overpayment and whether it had notified him of his right to request a review in relation to its decision. Mr G was advised by the Ombudsman to exercise his rights of review if he felt the overpayment was incorrect.

The investigation showed that the Council had notified Mr G of his appeal rights and had provided full explanations for its decisions. However, the investigation also found that the Council had delayed for four months in providing written confirmation of a meeting that had taken place on the case and that two letters from Mr G had not been answered until he made a formal complaint. It was held that this represented injustice to Mr G who was left in a position of uncertainty for some time. The complaint was therefore partly upheld on the basis that there had been some communication failings.

The Council accepted that this was the case and agreed to apologise to Mr G and make a payment of £100 for his time and trouble in bringing the complaint.
Case reference 201100607

Education Summaries

Upheld

December 2011 – Special Educational Needs – Cardiff County Council
Mr and Mrs K complained that the Council had not made the provision specified in their child's Special Educational Needs (SEN) statement at School 1. They subsequently applied for their child to be transferred to School 2 and complained that the transfer process had been unjustifiably delayed. Finally they complained that the Council had failed to respond adequately to their complaints to it.

The Ombudsman found that the provision in the statement (which related to a risk assessment at the School 1) had not been met. Whilst monitoring visits had been undertaken by Council staff, there was no suitable and sufficient risk assessment in place for Mr and Mrs K's child at School 1. The Council had also failed to respond to Mr and Mrs K's complaints to it. The Ombudsman therefore upheld these aspects of the complaint. However, he did not uphold the complaint that the transfer process was delayed as it was within the statutory timescales for amending a SEN statement.

The Council accepted the recommendations made by the Ombudsman. It agreed to review its risk assessment training to staff and to ensure that the wording of statements was clear in terms of who was responsible for making the relevant provisions. It also agreed to apologise to Mr and Mrs K and had appointed an officer to undertake a review of the complaints processes within the Education Service.
Case reference 201001284

December 2011 – Special Educational Needs – Bridgend County Borough Council
Mrs P's son, S, had a Special Educational Needs Statement ("SEN Statement") when the family moved to the Council's area. The Council is the Local Education Authority ("LEA") with statutory responsibility for assessing and implementing SEN provision in its area. After initially attending mainstream school, Mrs P moved S to an independent school (not under the LEA's governance), until his behaviour resulted in the school informally excluding him. Mrs P began educating S at home, but claimed that she had been promised a home tutor for S at a multi-agency meeting involving both the LEA and the Social Services Department. This did not materialise, and Mrs P said the Council had failed to provide S with education since then until they moved from the area (a period of some six months). Mrs P also complained that the move (and resulting expense) was directly caused by the LEA's failure to provide S with the home tutor as promised.

The investigation examined all the Council's records, including those of the LEA and Social Services, as well as seeking evidence from the council to whose area Mrs P had moved. Poor practice in not recording key information was found in some instances within the SEN department, and that this was not unique to this case. This included a discussion with Mrs P following a meeting where S's SEN needs were discussed. Internal e-mail communication showed that an officer had made an error about the home tutoring agreed for another pupil and that it was possible (although not certain) there may have been a miscommunication to Mrs P. However, the minutes of the meeting (within the Social Services file) clearly recorded that Mrs P was educating S herself at home, and had purchased the independent school curriculum to do so. A subsequent visit to Mrs P's home

by an Educational Psychologist also confirmed this. The evidence showed a pattern of Mrs P moving S between schools, educating him herself, and moving locations whenever Social Services' involvement began, as was the case in this instance. Mrs P's complaints were not upheld.

However, the Council's poor administration and communication with Mrs P had not helped, and had resulted in a protracted (arguably unnecessary) complaints process, for which the Ombudsman recommended that the Council apologise to Mrs P, and offer her redress of £150 for inconvenience, and time and trouble. He also recommended that the Council should review and audit its processes and record keeping within the SEN division, producing written guidance to those staff on good file administrative practice. The Council accepted the recommendations.
Case reference 201002501

November 2011 – Admissions procedures and appeals – Admissions Appeals Panel, Brynmawr Foundation School
Mr C complained that the School's Admission Appeals Panel - Brynmawr Foundation School had refused his son X, admission to Year 9 of the School. X was refused a place on the basis that the School's standard number was 150, and with 153 pupils on the roll the School was oversubscribed and the admittance of an additional pupil would result in prejudice to the efficient education or efficient use of resources and prejudice health and safety at the School. However the Blaenau Gwent Schools Information for Parents / Carers / Guardians – School Year 2011 - 12, stated that the standard number for School was 160.

The investigation determined that the standard number for the School was actually 160 not 150 as stated by the Admission Authority. As a result of the erroneous information provided by the Admission Authority, the Panel were unable to properly apply the two stage test when considering X's appeal, had it done so, it would have concluded that the School had not complied with its admission arrangements, because X's application had been refused despite there being availability. Furthermore, availability in the year group meant that the question of prejudice considered by the Panel was immaterial.

Mr C also complained that new information relating to X's previous behaviour and exclusion from his previous school was presented to the Panel the hearing. It was clear from the evidence that the new information was not only presented to, and considered by the Panel, it was the reason given by two of the Panel members when refusing the appeal.

The Ombudsman upheld the complaint. The Ombudsman made a number of recommendations to the Admission Appeal Panel, Brynmawr Foundation School, one of which related to X's inclusion to the School. The Ombudsman is pleased to note that since the draft report was issued, X was offered and has accepted a place at the School.
Case reference 201100094

Not Upheld

November 2011 – Admissions procedures and appeals – Admissions Appeals Panel, Tynewydd Primary School & Caerphilly County Borough Council

Mr B applied to the School for a place in its reception class for his daughter (whom I shall call Amy), but was refused because there had been too many applicants for the number of places available ("oversubscription"). The School's published standard admission number was 35, but there were 39 applicants for the reception class. The Council (as admissions authority) applied its published admissions criteria. As Amy did not live within the designated catchment area, had no siblings at the School, and lived too far from the School she was refused a place. Instead, she was offered a place at a school within whose catchment area she lived. Mr B appealed to the Panel, arguing that Amy had previously attended the School's nursery class and that Mr B's mother lived nearby who had been able to take Amy each day. If this arrangement could not continue, either Mr B, or his wife, would have to give up work in order to take Amy to the school offered, resulting in hardship for the family. The Panel applied the prejudice test, in which the Panel is obliged by law to consider whether the School would be prejudiced by admitting yet further pupils beyond the admission number and, if it would, whether the prejudice to the School is outweighed by the prejudice arguments/circumstances advanced by the child's parents. The Panel denied Mr B's appeal.

Mr B complained to the Ombudsman about: the Panel's composition and qualification of its members; that it had been unfair and had not properly considered his arguments; had rushed in its deliberations; and members had not worn name plates for the hearing. As against the Council, complaints included that it had used the wrong map to designate the catchment area for the School (as the School had been moved to a new site), and that its admissions officer had told him the waiting list for the School was closed on 31 August (which was before the School term began).

The investigation found that the Panel composition, membership and qualification had been in accordance with the statutory Code issued by the Welsh Government. Panel members had been introduced to Mr B at the outset of the hearing, so even if name plates were absent they had been identified. There was evidence that the Panel had taken into account Mr B's arguments and properly applied the prejudice test in taking its decision. Published information for parents explicitly stated that children were not guaranteed a place at the School's reception class if they had previously attended its nursery, and parents had been written to. The new School did not change the catchment area, as in applying the admissions criteria the distance was calculated from the new site to the applicant child's home. This in fact benefitted Mr B in the calculation, as the School was geographically closer, but he still lived outside its catchment area. The Council's officer had been correct in her comment about the waiting list as this was a date prescribed by the Welsh Government's Code. The Ombudsman did not uphold Mr B's complaints.

Case reference 201101455 & 201101685

Environment and Environmental Health Summaries

Upheld

December 2011 – Noise and other nuisance issues – Cardiff County Council
Mr C complained that Cardiff County Council failed to consult residents about the installation of a 5-a-side football pitch in a local Park. He also complained that the pitch was a source of noise nuisance and the Council failed to deal with his complaints about the issue properly.

Under the Town and Country Planning Act 1990, as the land was used previously as tennis courts, the Council did not require planning permission to install the pitch. There was therefore no requirement for the Council to undertake formal consultation in advance of such a change. The Ombudsman did not investigate Mr C's complaint that the Council failed to consult residents. Mr C was advised of that decision on 7 June 2011.

Under the Environmental Protection Act 1990, the Council must investigate complaints about noise nuisance and decide if the noise is a statutory nuisance. The Ombudsman can look at complaints about the way in which the Council has dealt with such noise nuisance complaints. However, he cannot undertake his own investigation of the nuisance and cannot reach a decision on whether the noise is a statutory nuisance. The Ombudsman also cannot overrule a council's decision about whether there is a statutory noise nuisance.

The Ombudsman concluded that there was no evidence to suggest that the Council had failed in its statutory duty in reaching the decision that the noise was not a statutory nuisance. This part of Mr. C's complaint was not upheld.

However, the Ombudsman did consider that the Council's failure to properly inform Mr C of its decision was unsatisfactory. He also found that the delay in responding fully to Mr C's complaint was completely unsatisfactory. The complaint about the Council's handling of his complaint was therefore upheld. The Ombudsman recommended that Mr C receive redress of £100 and an apology for the identified failings. He also recommended that the Council should develop a noise nuisance policy and provide appropriate training to officers to ensure its complaint handling service conforms to the relevant performance standards.
Case reference 201100104

Housing Summaries

Upheld

October 2011 – Repairs and Maintenance – Charter Housing Association
Mr & Mrs T complained that their landlord, Charter Housing Association (1973) Ltd ("Charter"), had failed to keep the under-floor heating system at their house in working order. The system installed was the recommendation of an Occupational Therapist made during the planning phase for the house, a specially adapted bungalow built to meet the needs of Mr & Mrs T's disabled son, J. Mr & Mrs T complained that despite their asking that the manufacturer of the system be called, Charter had instead repeatedly sent engineers to the house who had no specialist knowledge of the system. Consequently, abortive repair attempts were made over a period of 2 years before the system's designers were called establishing that the pump needed replacing. Later developments for the system meant that a separate boiler could be installed to isolate the hot water from the heating system, as an improvement. Mr & Mrs T complained that they had been without heat and hot water at times and that the ineffective system/abortive engineer attempts to repair it had meant their incurring higher energy bills. They wanted recompense for this. They also complained about Charter's handling of their formal complaint.

The investigation found that opportunity to establish the cause of the problem had been missed during a period of almost two years. A prudent landlord would have involved the manufacturers at an earlier stage-particularly given J's disabilities and needs. There had been a failure in the landlord's legal obligation to ensure the heating system was in proper working order. The complaint was upheld.

The improvements thereafter, were not something Charter could have implemented sooner, and so the complaint was not upheld for the later period. A number of factors made it impossible to ascertain with certainty the level of energy costs for the family, had there been no problems. There had undoubtedly been costs incurred during engineers' testing, and the family had been greatly inconvenienced, so that aspect of the complaint was partly upheld.

Whilst it was found that Charter did veer away from its published complaints policy in dealing with Mr & Mrs T's formal complaint, the deviation did not of itself prejudice Mr & Mrs T, so that aspect was not upheld. The Ombudsman, however, commented on Charter's failure to fully and promptly disclose documentation to his office, for which an apology was tendered. The Ombudsman recommended Charter apologise to Mr & Mrs T (and through them to J) and make a redress payment of £1,300. The Ombudsman also recommended Charter should arrange for the manufacturer to meet with Mr & Mrs T to provide full advice and that guidance on operating the system for optimum use, and undertake an audit and review of its complaint handling process. All recommendations were accepted.
Case reference 201001520

October 2011 – Other – Carmarthenshire County Council
Mrs W complained on behalf of her cousin who is elderly, registered blind and in ill-health. She said that following the award of a disabled facilities grant by Carmarthenshire County Council to provide a new bathroom to improve her bathing facilities, negligent workmanship by the builder appointed by the agent resulted in the demolition of the kitchen. Council officers said that it could not be rebuilt due to a lack of funding and directed that the kitchen be relocated in the dining room. Mrs W contends that her cousin was not consulted on that decision, which the Council was not entitled to take. The workmanship generally was very poor and Mrs J, her cousin, has been left with considerably reduced facilities and a property depreciated in value.

The Council responded to the complaint by contending that during the renovation it was discovered that the construction of the kitchen/scullery and bathroom area was of a sub-standard 'rat-trap' design and that there was no alternative but to demolish the structure. It says that Ms J and her agent were consulted at a site meeting before the decision was made to demolish and relocate the kitchen. Mrs J was told that she could have the kitchen re-built but would have to finance it herself because the grant monies had been expended. Derogatory remarks attributed to the officers were denied.

The opinion of the Ombudsman's Professional Advisor was sought and he expressed the view that until demolition exposed a section of brickwork that was not concealed beneath render and plaster, there was no indication that the unusual form of construction found was present. He considered the decision to demolish the substandard construction to be appropriate and that the Council was not in error in approving the revised layout. The Ombudsman, in these circumstances, could not criticise the decision reached, although maladministration was found due to the loss of the original occupational therapy report which assessed Mrs J's needs prior to the approval of the grant and was therefore an important document. Criticism was also made of poor record-keeping and lack of communication. It was recommended that Mrs J be paid £200 by the council in recognition of the failures.
Case reference 201000376

Not Upheld

December 2011 – Homeless person issues – Ceredigion County Council
Mr H complained that Ceredigion Council had initially failed to consider whether he was homeless and that, when it did determine he was homeless, it stated that he had agreed to remain in hospital when he had not. Mr H said that he did not agree to stay in hospital, and remained there for three months until he was permanently re-housed.

The Ombudsman found that there was some delay in processing Mr H's housing application, largely due to it being made over the Christmas period. Although the Council took longer to notify Mr H of its homelessness decision than is recommended in the Welsh Government's Code of Guidance, the Ombudsman took the view that the delay was not excessive given the circumstances of the case. He also concluded that Mr H had not been caused an injustice as attempts were being made to identify suitable accommodation for him before the formal homelessness decision was issued.

Turning to the length of time Mr H remained in hospital, the Ombudsman agreed that this was not ideal; however, he also accepted that there was a shortage of suitably adapted properties available and that the Council's decision that it would be less disruptive for Mr H to move once to permanent accommodation, rather than being moved to temporary accommodation (which was likely to need adaptation) and then being moved again to permanent accommodation, was one it was entitled to take. The Ombudsman did not uphold the complaints.
Case reference 201100520

November 2011 – Applications, allocations, transfer and exchanges – Pembrokeshire County Council
Mr L complained that the Council had failed to take action to address a noise nuisance being caused by tenants in the flat above his; had failed to rectify damp and condensation problems in his flat; and had failed to properly process his application for a housing transfer.

The Ombudsman found that, although the noise coming from the flat upstairs was a nuisance to Mr L, the Council had taken appropriate action to assess it and had reasonably determined that it did not constitute a statutory nuisance over which formal action could be taken. The Ombudsman found that the Council had made a reasonable offer to try to reduce the impact of noise from above by installing additional soundproofing.

The Ombudsman found that the Council had taken some action to resolve the problem of damp/condensation and that it had made a reasonable offer to install additional measures to further improve the situation.

Finally, the Ombudsman found no evidence to suggest that Mr L's housing transfer application had been dealt with other than in accordance with the relevant policy and procedure. Accordingly, the Ombudsman did not uphold Mr L's complaints.
Case reference 201100535

Planning and Building Control Summaries

Upheld

November 2011 – Unauthorised development – Gwynedd Council
The complainants, Mr and Mrs P, complained on behalf of themselves and fourteen other residents that the Council had not properly controlled the use of a caravan and camping campsite. They said that their homes shared an access road with the campsite and as it was a narrow single track lane they were frequently inconvenienced by having to reverse in the lane to allow vehicles through. They said that cars had been scratched due to the narrowness of the lane and people with driveways had had them damaged as they were used as passing places.

The complainants also said that although the campsite had been refused planning consent on many occasions, consent had recently been granted subject to a section 106 agreement being signed concerning the use of the campsite. This had left them concerned as to whether the application had been properly considered, given the history of complaint and non-compliance by the campsite owner. They were also unclear as to the current position as they did not know whether the s106 had been agreed; they had seen some work commencing on the site and did not know if it had been properly authorised.

They complained about inadequate monitoring of the site, a general lack of communication on the part of the Council and that it had failed to correctly determine the permitted developments rights for the site.

The investigation found that the Council had correctly determined the permitted numbers for the campsite and had, in general terms, met statutory obligations in respect of consultation and notification. However, it found other failings, notably that the Planning Committee had failed to record its reasons for going against an officer recommendation to reject the planning application; that there had been a delay in issuing a draft s106 agreement to the campsite owner; and also that it had taken a year in total for the s106 agreement to be signed. There were also deficiencies identified in the Council's monitoring of the site.

The Ombudsman concluded that he was not satisfied that there were grounds for recommending reconsideration of the planning application. He believed it was not in the best interests of the complainants for him to do so as the approval and conditions now in place had resulted in planning gain and placed the campsite on a better footing for future monitoring. He recommended that the Council ensures that future planning committees should record the reasons for not following officer advice, should they choose to do so in the future.

The Ombudsman recommended that the Council should apologise in writing to all of the complainants for the failings identified in this report and that, in addition, it should make a payment in the sum of £350 to Mr and Mrs P for their time and trouble in bringing this complaint and towards their costs.
Case reference 201000844

October 2011 – Building Control – Monmouthshire County Council
Mr M complained to the Ombudsman about the way in which Building Control Service of Monmouthshire Council dealt with the approval of building work undertaken at his property. Mr M was aggrieved that Building Control Service failed to monitor the progress of the building work carried out by his contractor. He complained that the Building Control Service issued completion certificates for the work confirming that the work met building regulations, despite having possession of an electrical report which identified a number of items that required (in one case urgent) attention and which the electrical inspector reported as not satisfying building regulations. Mr M also complained about aspects of the complaint handling process.

Following receipt of professional advice, the aspect of Mr M's complaint which related to the Building Control Service's inspection regime was upheld since there was a possibility that an opportunity to identify some of the defective work that was undertaken might have been lost. However, despite identifying significant maladministration in the manner in which the Council dealt with the issuing of the certificate of completion, it was concluded that Mr M had not suffered any injustice as a result of the issuing of the certificate of completion because he was aware of the matters requiring attention and that the issuing of the certificate did not alter this requirement per se. Mr M's complaint about the Council's handling of his complaint was also upheld.

The Ombudsman recommended that Mr M receive redress of £500 for the failings identified and that the Council changed its procedures and approaches to ensure its service conformed to the relevant performance standards.
Case reference 201001884

Roads and Transport Summaries

Upheld

December 2011 – Other – Isle of Anglesey County Council
Mr W complained that the Council had failed to take effective measures to prevent surface water ponding on the road outside his property and that as a consequence, surface water was washed onto the house by passing vehicles and caused problems associated with dampness. He also complained that when the Council undertook a highway drainage scheme, it failed to provide a footway wide enough to comply with current standards for disabled users, and that the Council failed to deal with his complaints in a satisfactory manner.

Mr W's complaint about the surface water ponding was not upheld. The information showed that the Council had addressed the matter, and had acted reasonably in implementing a scheme which was intended to address the problem even though Mr W disagreed with it. The Council had also provided Mr W with an opportunity to inspect the front of his property, and consider installing a damp proof course. Although the Council was not able to provide satisfactory records relating to the inspection, cleaning and maintenance of the new drainage scheme, ponding problems had not occurred to the same extent as had been the case prior to the completion of the scheme. The Council has also introduced procedures for inspecting and recording the inspection and maintenance of its gulley systems on a regular basis.

The complaint about the footway was also not upheld. The Council had considered the needs of disabled persons, and its view that it was not reasonably practicable to widen the footway was one it was entitled to reach.

However, Mr W's complaint about the way the Council dealt with his complaint was upheld. It was not apparent that his request that a further matter be considered as part of his complaint was adequately dealt with. As a consequence, he was put to the trouble of pursuing the matter further with the Council and his Assembly Member.

The Council agreed to make a payment of £100 to Mr W. It is also taking steps to adopt the new public services model complaints policy in line with recent guidance issued by the Welsh Government.
Case reference 201001744

Social Services Summaries - Adult

Upheld

November 2011 – Other – City and County of Swansea
Mrs D complained about the City and County of Swansea's ("the Council") handling of a Protection of Vulnerable Adults ("POVA") investigation. She explained that she made allegations relating to her ex husband's care at a Care Home in 2009/2010, in which he had resided and she had worked. Mrs D stated that the Council allowed the owners of the Care Home to investigate the matter rather than ensure an independent review of her allegations. She said that the Council's handling of the matter left her with the view that guilty parties had escaped censure and that the Council's systems for protecting vulnerable adults were wanting. She stated that the matter had been distressing and time consuming to pursue.

The Ombudsman upheld Mrs D's complaint to an extent. Whilst having misgivings about the Council's decision to allow the Care Home to investigate itself in this case, he acknowledged that guidance allows that to occur. However, he identified maladministration in the Council's handling of the case. He concluded that the Council did not properly record its decision making and did not implement guidance appropriately. This meant that the merits of its decisions were not adequately evidenced.

The Ombudsman concluded that if the Council had thoroughly applied the guidance concerning decision making, it would have been in a better position to reassure Mrs D that the investigation into her allegations was fair. To that extent, he upheld her complaint. The Ombudsman recommended that the Council pay Mrs D £350 and made other process related recommendations. The Council agreed to implement the recommendations.
Case reference 201100218

Various Other Summaries

Upheld

December 2011 – Miscellaneous – Rhondda Cynon Taf County Borough Council
Mr N complained that the Council had withheld relevant documentation from him which he had previously requested under the Freedom of Information (FOI) Act. Without this documentation, he had to pursue an expensive claim for possessory title to land that he was occupying for business purposes. The Council had sold the land to a neighbouring occupier. The Council provided the document to him two days prior to the hearing before the Adjudicator to H.M. Land Registry. This complaint followed on from a previous Ombudsman's report (ref: 201000341) which identified maladministration in the pre-sale inspection of the land in question.

The Ombudsman found maladministration in that the Council failed to locate a document in its possession over a period of several years and, even once it had done so, it failed to provide this to the complainant despite the previous FOI request. The Ombudsman was satisfied that this led to a considerable injustice to the complainant. He recommended that the Council pay Mr N's reasonable legal fees incurred in respect of the information requests and his tribunal claim for the land.
Case reference 201002696

November 2011 – Miscellaneous – Neath Port Talbot County Borough Council
Ms H complained that the Council had unfairly restricted street trading on a beachfront; had unfairly prevented her from trading in beach goods despite granting her a licence to do so; had prevented her from trading at a beach festival; and had not properly dealt with her complaint.

The Ombudsman found that the Council was entitled to decide who could trade on its land. The decision to restrict the number of street traders was one the Council was able to take, and the reason given – to encourage permanent traders – was not wholly unreasonable. The Ombudsman also concluded that the Council was free, as the landowner, to decide which traders attended the festival. The Ombudsman found that the Council was entitled to revoke Ms H's lease to trade in beach goods as it had evidence that she was trading in breach of the conditions of her lease and street trading licence, and it had warned her of the consequences if she continued to do so. The Ombudsman did not uphold these parts of Ms H's complaint.

The Ombudsman partly upheld Ms H's complaint about how her complaint had been dealt with. He found that there had been some delay and that Ms H's request that her complaint be dealt with at stage 3 of the Council's then complaints procedure had been overlooked. The Council agreed to apologise to Ms H for these failings.
Case reference 201100472

Not Upheld

October 2011 – Licensing – Rhondda Cynon Taf County Borough Council
Mr C, who is a taxi operator, complained that there was maladministration in the way the Council dealt with his attempts to renew a private hire vehicle licence. In particular, he complained that the Council failed to call him back to make arrangements for the licence to be renewed. Mr C said that because of this, the licence expired and the Council subsequently refused to renew it "out of time".

The Ombudsman concluded that the Council should have made more effort to call Mr C back given that it was its procedure at that time to ask operators to leave their details, which were then passed on to a licensing officer who would call them back. That said, the Ombudsman did not find that the Council was solely or largely to blame for the licence not being renewed as Mr C could have done more himself to ensure this was done. The Ombudsman therefore only upheld the complaint to a limited extent.

The Ombudsman recommended that the Council apologise to Mr C for the failings he had identified.
Case reference 201002378

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

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Further information about the service offered by the Public Services Ombudsman for Wales can also be found at www.ombudsman-wales.org.uk