

The Ombudsman's Casebook

Issue 4 April 2011

Inside this issue

A word from the Ombudsman 1

Case Summaries

Health 4

Planning and Building Control 26

Housing 39

Education 48

Adult Social Services 49

Roads and Transport 52

Children's Social Services 53

Various Other 57

More Information 59

A word from the Ombudsman

One of my commitments in publishing the Casebook was to identify trends in cases considered by my office and to make recommendations for improvements to public services in Wales accordingly. Before compiling this issue, my office had growing concerns about the issue of care for people at the end of their lives. Many of the people concerned are older people, but the issues are not exclusive to them.

We have seen a number of common characteristics in cases including:

- failures to recognise the fact that death is imminent thus denying relatives the chance to be present,
- failure to monitor patients appropriately, particularly in respect of hydration and nutrition,
- failure to act on trends identified in monitoring,
- failure to inform patients and relatives about the likely outcome,
- failure to properly discuss decisions not to resuscitate,
- failure to institute palliative care at an appropriate stage, and
- a lack of privacy and respect.

(Continued overleaf)

Our concern about these issues was underlined by a series of reports about the quality of care received by older patients in the NHS in Wales and England published recently which received widespread media coverage. These reports included one from the UK Parliamentary and Health Service Ombudsman for England entitled 'Care and Compassion?'; another by the Older People's Commissioner for Wales entitled 'Dignified Care? The experiences of older people in hospital in Wales'; and a report by the Patients Association entitled 'Listen to patients, Speak up for change'. These issues were also featured on the BBC Wales "Week in Week Out" programme.

In February 2011, I issued a public interest report (200900780) which identified that, amongst other findings there had been a failure to obtain informed consent for a procedure, that the patient had been discharged without proper planning and before a full clinical investigation had been undertaken, and a failure to note the deterioration in the condition of the patient. As well as highlighting serious failings in respect of the care received by this patient at Glan Clwyd hospital, the report also noted that these failings had been identified in previous investigations by this office. It is clearly of serious concern that such failings continue to arise in the same hospital. The details of these cases are provided below.

In January 2011, I issued another report concerning Glan Clwyd hospital (200901463) which found that nursing staff had failed to act on observations indicating there had been deterioration in a patient's condition. A report issued in June 2010 (200901957) found that there had been a lack of recognition of the severity of a patient's illness, and a delay in the patient's treatment. In this case, a nurse had failed to recognise that a patient was very ill and in need of an urgent medical review. As far back as April 2009, an investigation (200800304) found that there had been a failure to properly assess the needs of a terminally ill patient.

However, my office has also noted similar examples in relation to other Health Board areas. For example, one report (201000750) found that clinical staff at one hospital in the Cwm Taf Health Board area failed to give due attention to tests carried out following surgery, with the result that staff missed early indications that complications had arisen. A further report (200900775) in relation to the Powys Teaching Health Board area found that, had a patient's condition been better monitored, it is possible that changes in the patient's condition could have been detected sooner, and the patient's family could have been with him at his death.

In another case (200802597), the health body was found to have failed to secure the comfort and safety of an extremely vulnerable patient. In a further case (200902364), I noted that some of the patient's records were incomplete, and there was concern at the standard of communication with the patient's family.

The frequency and similarity of reports relating to Glan Clwyd Hospital is clearly of serious concern. However, the fact that there are other examples falling within other Health Board areas illustrates that these problems do arise elsewhere. This finding was reinforced by the conclusions of the reports mentioned above. The members of Health Boards and senior staff need to take action to satisfy themselves that these serious failings are not repeated in their hospitals. Similarly, Health Inspectorate Wales need to factor these findings into their work and I will be drawing them to the attention of HIW and the Chairs and Chief Executives of the Health Boards.

Following the publication of the Parliamentary and Health Service Ombudsman's report setting out her concerns about the NHS in England, I received a letter from a woman whose late father's treatment at Glan Clwyd Hospital had been the subject of a complaint to my predecessor – 10 years ago. Like many other complainants she had wanted to ensure that no one else would experience the shortcomings that had occurred in the case of her father. She had received such assurances, but having seen reports about Glan Clwyd Hospital on my website, was saddened to realise that the assurances could not be relied on.

I have more than once received such assurances, that action would be taken to prevent a repetition. In the event, either the action taken was not effective, or it was not sustained. If Health Boards do not learn from complaints, then patients will continue to suffer needlessly. I intend to meet with the relevant Chairs to reinforce my concerns. I would remind the independent members of boards that they have a key role to play in representing the interests of patients, and they should not blandly accept assurances but instead take responsibility for satisfying themselves that patients at the end of their lives are receiving appropriate palliative care and being treated with the respect and dignity which they deserve.



Peter Tyndall
Ombudsman

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.

March 2011 – Regulation and Inspection – Healthcare Inspectorate Wales, Care and Social Services Inspectorate Wales and Welsh Assembly Government

Mr & Mrs A's teenage daughter was diagnosed with a terminal illness and was cared for at a children's hospice. The family's wish was to spend as much time together as possible and for Mr & Mrs A to manage many aspects of their daughter's care. Relations between Mr & Mrs A and hospice staff became strained. The hospice was concerned that its access to Mr & Mrs A's daughter and to her room was limited and they asked Healthcare Inspectorate Wales (HIW) for advice regarding possible breaches of relevant regulations. HIW sent in an inspector and an expert reviewer who listened to what the hospice had to say, and gave a view. The hospice subsequently met with Mr & Mrs A and said that staff must be allowed full access to their daughter and accept input from the care team otherwise she would be discharged.

Mr & Mrs A complained to HIW about this, about other concerns regarding care at the hospice, and subsequently also about HIW's involvement in the situation. HIW asked its expert reviewer to investigate the complaints. It later transpired that HIW did not have authority to conduct a complaints investigation, although it could look at matters involving the Regulations. The Welsh Assembly Government's complaints unit subsequently became involved.

The Ombudsman does not have jurisdiction for the hospice and was unable to investigate Mr & Mrs A's concerns about the hospice's actions. The Ombudsman investigated complaints against HIW and the Welsh Assembly Government. (A linked, and minor, complaint against the Care & Social Services Inspectorate for Wales was investigated and was not upheld.)

The Ombudsman found that HIW representatives had heard only the hospice's account of events and failed to seek the views of Mr & Mrs A and their daughter, particularly regarding her right (subject to limitations) to give or withhold consent for examinations. The Ombudsman found that HIW had focussed on the interests of hospice staff rather than the child and her family. However, the Ombudsman concluded that HIW had not mis-advised the hospice or threatened it with breaching the Regulations. The Ombudsman criticised the appointment of HIW's expert reviewer as complaints investigator as she was not sufficiently independent, having been involved in advising the hospice. He also criticised HIW's muddled handling of Mr & Mrs A's complaints, and considered that the Welsh Assembly Government's complaints unit could have intervened when it became apparent that Mr & Mrs A were unhappy with HIW's handling of the complaint.

The Ombudsman made a range of recommendations to HIW and the Welsh Assembly Government all of which they agreed to implement. The Ombudsman commented on his lack of jurisdiction for the hospice, and that there was no other independent body able to investigate Mr & Mrs A's concerns about the hospice. This is profoundly unsatisfactory. The Ombudsman asked the Welsh Assembly Government to consider what action it could take to bring the hospice into his jurisdiction.

Case reference 200901222, 201000061 & 201000062

February 2011 – Clinical treatment in hospital – North Wales NHS Trust (now Betsi Cadwaladr University Health Board)

Mrs R made a number of complaints to the Ombudsman regarding the care of her husband at Glan Clwyd hospital in 2008. Mr R sadly died at the hospital on 29 December 2008. He had been ill since October 2008, and had been diagnosed with cancer on 10 December.

The Ombudsman upheld several of Mrs R's complaints. The key findings were as follows:

- that Mr R's consent for a biopsy was not informed consent as there was insufficient time for him to properly consider the procedure and ask questions;
- that Mr R was discharged on Christmas Eve without proper planning and before full clinical investigations had been undertaken;
- that when Mr R was re-admitted to the hospital on 28 December he was not seen by a senior clinician;
- that it was not reasonable for the ward sister to have insisted on weighing Mr R, who was by this time very ill;
- that clinical staff failed to recognise the seriousness of Mr R's condition or his deterioration.

The last point in particular caused the Ombudsman concern as this issue had arisen in previous investigations about care at Glan Clwyd hospital. The Ombudsman made a range of recommendations regarding patient consent, review by a consultant, end of life care, and discharge planning; and he asked the Health Board to instigate its own investigation into Mr R's care from October 2008 onwards, and into the care of other patients whose complaints about Glan Clwyd hospital had been the subject of investigation by the Ombudsman. The Ombudsman recommended that the Health Board apologise to Mrs R for the failings identified during the investigation, pay her £250 for her time and trouble in pursuing the complaint, and reimburse her £50 charged for copies of Mr R's clinical records. The Health Board agreed to implement all of the Ombudsman's recommendations.

Case reference 200900780

January 2011 – Clinical treatment outside hospital – Cardiff and Vale NHS Trust (now Cardiff and Vale University Health Board)

Mrs F complained about the standard of care afforded to her late son, X, by the Trust's Mental Health Services, before his death in October 2008 (when he took his own life). During his care period he had expressed a suicidal intent, taken an overdose, and had harmed himself whilst away with Mrs F. She complained that X had been discharged from the Trust's Crisis Home Treatment Team's ("Crisis Team") care too soon, after 2 ½ weeks, when he went away with her. Further, when he attended a Trust hospital immediately from the airport on his return, seeking admission, he was denied. Mrs F complained that the Trust had failed to admit him to hospital throughout because of a shortage of beds.

Following advice from the Ombudsman's clinical advisers, the complaint was mostly upheld. The investigation found that:

- the threshold for admission to a hospital bed (such admission being governed solely by the Crisis Team) appeared to be at a high level given there was no clear policy guidance or definition as to what constituted a "severe case" warranting admission;
- the high bar coloured the way in which X was dealt with, given he had not previously been known to the Trust's services. This was particularly evident immediately following his return from the trip with Mrs F, when he had self harmed;
- there was no clear guidance in place as to what should happen when patients recently discharged from the Crisis Team's care presented themselves at a hospital front desk, out of hours, requesting admission.

The Ombudsman did not uphold the complaint that any shortage of beds had influenced the decision not to admit X, as he was satisfied that a bed could have been sourced elsewhere if required. Rather, the reason was the high threshold for admission. He could not either find that X would not have ended his life when he did had he actually been admitted as hospital admission is not the solution for many patients. As a matter of good practice, the Ombudsman also found that the Trust should have undertaken a more thorough and objective investigation into X's death (a Root Cause Analysis – RCA), as opposed to the Multi Disciplinary meeting involving those who had treated him that took place. This would have resulted in identifying the lack of guidance about presenting out of hours, which the Trust agreed was required.

The Ombudsman recommended that the Trust apologise to Mrs F for the failures identified and offer her redress for the need to pursue the investigation (which might have been avoided had a RCA been undertaken). Further recommendations included a review of the threshold and criteria for admission to hospital, a written procedure for a patient's 'out of hours' presentation at hospital, and a reminder to senior staff within Mental Health Services about the need for a RCA investigation particularly where the death of a patient occurs.

Case reference 200802452

Upheld

March 2011 – Clinical treatment in hospital – Cardiff and Vale NHS Trust (now Cardiff and Vale University Health Board)

Mrs A's late husband, Mr A, had Burkitt's lymphoma. Mrs A complained that the Trust did not enable Mr A to give informed consent to his chemotherapy treatment. She suggested that this treatment might have been inappropriate for him because of his medical history. She complained about the Trust's management of this treatment and the emergency treatment provided for Mr A when his condition deteriorated. She suggested that the specialist support given to her and Mr A was inadequate. She expressed concern about cleanliness and infection control. She complained about the attitude and behaviour of staff members. She said that the support provided for her, following Mr A's death, was lacking. She also indicated that she was dissatisfied because the Trust did not prepare and process a discharge summary, in respect of Mr A, promptly.

The Ombudsman fully upheld the consent element of Mrs A's complaint. He recommended that the Board should prepare written information which complies with the chemotherapy consent guidelines. He partly upheld those parts of Mrs A's complaint which concerned emergency treatment, specialist and bereavement support, cleanliness and infection control. He asked the Board to develop a mechanism for improving the specialist support given to newly admitted patients and their families. He recommended that the Board should prepare a practical information leaflet for them. He asked it to prepare a checklist of the documents and/or leaflets that staff members, working within its Haematology Directorate, should give to patients and their families, as a matter of routine. He recommended that the Board should apologise to Mrs A for the failings identified. The Board agreed to comply with the recommendations made. The Ombudsman did not uphold the chemotherapy treatment, the staff member conduct or the discharge summary aspects of Mrs A's complaint.

Case reference 200900687

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

Mrs X complained about aspects of her mother, Mrs Y's, care at the University Hospital of Wales shortly before her death in December 2008. She believed that the IV morphine that was administered to her mother was unnecessary as her mother had not complained of pain, and contributed to her death immediately afterwards. She also said that Mrs Y's family had not been consulted about the making of a DNAR direction.

The Ombudsman found that the morphine had been appropriate, and the dose administered was a very small dose. Mrs Y was very ill and her death was inevitable, but was probably unintentionally hastened by the administration of the drug. Although the Ombudsman identified some shortcomings, in particular with regard to record keeping, they did not have any effect on the outcome for Mrs Y.

The Ombudsman concluded that the discussion with Mrs Y's daughter regarding the DNAR decision had not been adequate; the DNAR decision had not been clearly explained to Mrs X. Neither had the DNAR direction been completed properly. The Ombudsman partially upheld the complaint.

Case reference 201000090

March 2011 – Clinical treatment in hospital – Hywel Dda NHS Trust (now Hywel Dda Health Board)

Ms A complained about the care and treatment she received in a hospital managed by the former Hywel Dda NHS Trust. The hospital is now managed by Hywel Dda Local Health Board ("the LHB"). Ms A complained about poor ward design; insufficient nursing staff available to attend to her care needs; faulty equipment which led to poor pain control; cleanliness of the ward and other infection control concerns; and that her discharge from the intensive care unit following her operation was too early. Ms A also complained about poor complaint handling.

The Ombudsman upheld several aspects of her complaint including that concerning the cleanliness of the ward, poor pain management and poor complaint handling. The Board recognised shortcomings in the ward's design and a complete refurbishment of the ward was undertaken. The Board also took steps to appoint additional staff. The Board agreed to apologise to Ms A, and pay her £100 for her time and trouble in pursuing her complaint as well as other action.

Case reference 200901949

March 2011 – Clinical treatment in Hospital – Abertawe Bro Morgannwg University Health Board

Mrs X had complained to the Independent Review Panel ("the Panel") about issues relating to the care and treatment that her late husband ("Mr Y") had received at hospital. She complained to this office that the Trust had failed to respond to the concerns raised by the Panel and the recommendations that it had made. Mrs X also complained about a false report of an echocardiogram supposedly performed on her husband before his operation. Mr Y suffered a heart attack after the operation. Mrs X considered that the pre-operative assessments had been inadequate.

The investigation found that there was insufficient evidence that a pre-operative echocardiogram had been performed on Mr Y. The complaint was not upheld. The investigation found that there were maladministrative shortcomings in the Trust's post-Panel response, which caused Mrs X an injustice. This complaint was therefore upheld. It was recommended that the LHB took steps to address the administrative shortcomings highlighted by this case and make a payment of £50 to Mrs X in recognition of the time and trouble spent pursuing her complaint (the Trust had already acknowledged and apologised for its poor complaint-handling).

Case reference 200901019

March 2011 – Clinical treatment outside hospital – Cwm Taf NHS Trust (now Cwm Taf Health Board)

Mrs G, who is right-handed, complained about her clinical treatment by the Health Board following an accident she suffered in December 2007, when she fractured her right humerus. In particular, she complained that there had been a failure / unreasonable delay in considering if she had a non-united fracture, and in recognising it once consideration was given. Consequently, she said that she had suffered unnecessary pain and a delay before remedial surgery was carried out (in May 2010). She still had restricted shoulder movement.

The Ombudsman's investigation found a number of failures in Mrs G's case. These included:

- a diagnosis of Mrs G's non union fracture ought to have been considered up to 12 months earlier than it was (possibly indicative of diagnostic limitations within the department);
- recognition would have resulted in earlier surgery with better outcome prospects, and a shorter period of pain;
- unacceptable delay between an MRI scan and a follow-up clinic;
- unacceptable practice of taking only 1 x-ray view (instead of 2).

Overall, Mrs G's care should have been better clinically managed. The Ombudsman upheld the complaint. His recommendations included: an apology to Mrs G; redress of £3000 for the unnecessary pain / inconvenience caused by the delay and her need to pursue the complaint; a review of the practice of taking only one x-ray view; and a review of orthopaedic clinical and complaints data for similar cases for reassurance of diagnostic ability. The Health Board agreed to implement all the recommendations.

Case reference 201000123

March 2011 – Clinical treatment in hospital – Cwm Taf Health Board

Mrs AW and Mr WW complained to the Ombudsman about the care their husband and father, Mr DW (deceased), received during his stay in Prince Charles Hospital (now managed by Cwm Taf LHB) in March 2008. Their concerns included poor communication and record keeping by staff, inadequate basic nursing care and a failure to ensure that Mr DW received adequate pain relief, nutrition and liquids. They were also concerned about remarks made about them in a report issued by an Independent Review Panel who considered their complaint about Mr DW's care.

The Ombudsman found that there was no evidence to suggest that Mr DW was not given adequate pain relief or that there was a delay in giving him liquids and nutrition. Some of Mr DW's records were incomplete, and, as the LHB only partially addressed the concerns about conflicting advice given by staff when responding to the family's initial complaint, he partially upheld this aspect of the complaint. The Ombudsman also expressed concern about the standard of communication with the family throughout the complaint handling process and the content of some of the letters sent to them. He also found that negative comments about the family which were included in the Panel's report were not supported by the patient records and added no value to the report in the context of clinical governance and the development of action plans; he therefore upheld this part of the complaint.

The Ombudsman recommended that the LHB apologise for the failures identified by his investigation. He also recommended that the Independent Review Panel apologise for the comments included in its report and reissue the report omitting those personal comments.

Case reference 200902364 & 201000157

March 2011 – Clinical treatment outside hospital – Velindre NHS Trust and Cardiff and Vale NHS Trust (now Cardiff and Vale University Health Board [UHB])

Ms F complained about the care of her late father ("M") by both the Trust and UHB before his death, from primary cancer of the bladder. In particular, Ms F complained that: M's complaints of foot pain were ignored; there was a failure (and delay) in diagnosing secondary cancer (metastases) to his foot and to include M's feet in a scan (which may also have diagnosed the metastases sooner); the delay meant M did not receive any treatment to his foot earlier and suffered unnecessary pain (including being required to undergo physiotherapy).

Following advice from the Ombudsman's clinical advisers, the complaint was upheld in part. It was not possible, given a conflict of evidence, to conclude that M had made complaints sooner about foot pain. An abnormality (indicating metastases) on the x-ray taken at the UHB's hospital, following a referral from M's GP, ought to have been noticed by the UHB over 4 months earlier than it was, resulting in M being sent for physiotherapy to treat his ankle. M suffered unnecessary pain in that period, albeit there was evidence the Trust made every effort to control M's pain after the diagnosis. There was no clear evidence (from either the Trust or UHB), as to why the feet were omitted from the scanning process (the Oncology adviser being of the clear view it should be routine to include them). Had they been, it was possible that the foot metastases could have been diagnosed a month before the x-ray was taken. However, this would not have affected the outcome for M.

The Ombudsman recommended the following: redress by way of apologies to Ms F; a time and trouble payment of £300 (borne equally by the Trust and UHB), a review of the protocols for scanning to ensure the feet were included; and a review of radiology working practice to ensure that theirs is written reporting to primary care referrers. Both the Trust and UHB agreed to the recommendations.

Case reference 200902137 & 200902456

February 2011 – Claim for reimbursement - Powys Teaching Health Board

Mr S complained about Powys Teaching Local Health Board's reconsideration of his claim for reimbursement of the cost of a knee operation he had in Belgium in 2004. In particular, Mr S complained that there was maladministration in the way two Individual Patient Commissioning Panels (IPCPs) considered his claim in March 2008 and September 2009; that there was undue delay in providing him with copies of policies and procedures, and in responding to his requests for clarification about those policies and procedures; and that the Health Board held an appeal panel in February 2010 to consider the actions of the September 2009 IPCP despite Mr S withdrawing his request for an appeal.

The Ombudsman upheld Mr S's complaints about the operation of the IPCPs. He found that they failed to ensure they had adequate and relevant clinical information on which to base their decisions and failed to take into account relevant guidance. The Ombudsman did not uphold the complaints about requests for information. While the Ombudsman appreciated that Mr S would have preferred a quicker response, the Health Board had provided the information within the statutory timescales. Finally, the Ombudsman upheld the complaint about the appeal panel as he did not consider it procedurally correct to hold the panel when Mr S had withdrawn his appeal.

The Ombudsman recommended that the Health Board should apologise to Mr S for the failings identified in the report and he also made some procedural recommendations aimed at improving the operation of IPCPs and appeal panels in the future. The Health Board agreed to implement the recommendations.

Case reference 201000857

February 2011 – Clinical treatment in hospital – North West Wales NHS Trust (now Betsi Cadwaladr University Health Board)

Mrs A complained on behalf of her elderly mother, Mrs B, about the standard of her treatment and care whilst she was a patient at Penrhos Stanley Hospital. Mrs A said that the hospital staff failed to provide appropriate and timely treatment of her mother's pressure ulcer. Consequently, Mrs B developed a painful and severe pressure ulcer to her right heel that took several months to heal. Hospital staff also failed to arrange ongoing physiotherapy input for Mrs B upon discharge from hospital which resulted in Mrs B losing her ability to self mobilise. Finally, Mrs A was dissatisfied with the Trust's response to her formal complaint which she said did not accord with the timescales and procedures set out in its complaints policy.

The Ombudsman partly upheld Ms A's complaints. The investigation found that whilst Mrs A's physiotherapy treatment was managed satisfactorily and the decisions that were made were appropriate, both the standard of care and treatment of Mrs B's pressure ulcer and the response to Mrs A's complaint about the matter, fell below that which would reasonably be expected. The Ombudsman found that the Trust had failed to secure the safety and comfort of an extremely vulnerable patient and only by pursuing the complaint with his office had Mrs A received answers to some of her concerns. He recommended that the Health Board should apologise to Mrs A for the failings identified and make her a redress payment of £250 for her distress and inconvenience. The Health Board also agreed to review, identify and introduce measures to address the shortcomings in pressure care identified by the investigation.

Case reference 200802597

February 2011 – Continuing Care – Cardiff Local Health Board (now Cardiff and Vale University Health Board)

In February 2006 following hip surgery, Mr T's and Mrs H's mother, Mrs T, who also suffered from Dementia, was transferred to St David's Hospital, Cardiff for rehabilitation. In May 2006 the complainants were told that Mrs T had been assessed for, but was not considered eligible for, Continuing NHS Healthcare funding. Although, further assessments were carried out and a Review Panel considered Mrs T's entitlement in late 2007, her family were told she would be ineligible to have her care costs outside of hospital met by the NHS. Her family questioned that and sought legal help to challenge that decision. Mrs T remained in hospital until she died in December 2009. The family's solicitor complained to the Ombudsman that the assessments for NHS funding were flawed and that that had prevented Mrs T from being transferred to a suitable care home.

The Ombudsman found that although Mrs T's family attended several meetings with hospital staff, there was a general lack of understanding about and inconsistencies in the Continuing NHS Healthcare assessment process which made it difficult for the decisions reached to be adequately

explained to Mrs T's family. He noted that up until her death Mrs T's needs were met in full in the hospital and that her family were not held responsible for any care costs or put under pressure to move her to a care home. However, he upheld the complaint as Mrs T's eligibility for NHS funding had remained unclear throughout much of her admission and even when she was later considered eligible for funding that decision was not properly conveyed to her family or their representatives. The Health Board agreed to pay Mr T and Mrs H £250 each for their time and trouble in pursuing their concerns and a further £100 each for the anxiety they had suffered. The Health Board also agreed to meet them to discuss their concerns and to explain the action being taken to improve communication and to train staff involved in assessing Continuing NHS Healthcare eligibility.

Case reference 200800113

February 2011 - Clinical treatment in hospital – Cardiff and Vale NHS Trust (now Cardiff and Vale University Health Board)

Mr J complained about dental treatment that he had received in a hospital managed by the former Cardiff and Vale NHS Trust ("the Trust"). The hospital is now managed by the Cardiff and Vale University Local Health Board ("the LHB"). Mr J said that his jaw broke as a result of the extraction of two wisdom teeth. He stated that this necessitated two operations and further treatment, causing him pain and distress, inconvenience and lost time.

The Ombudsman upheld Mr J's complaint. He found that Mr J's jaw was probably broken as a result of his acquiring an undiagnosed disease called osteomyelitis. The Ombudsman concluded that, although a rare complication of wisdom teeth extraction, his clinicians should have been able to identify it. If they had, Mr J would probably have only endured one operation and suffered less generally. The Ombudsman recommended that the LHB pay him £500 as a token compensatory payment and take action to improve clinicians' knowledge of osteomyelitis. The LHB agreed to implement the Ombudsman's recommendations.

Case reference 200900291

February 2011 – Patient supervision – Betsi Cadwaladr University Health Board

Ms X's mother, Mrs Y, who suffers from dementia, attended Colwyn Bay Community Hospital for respite. When Ms X arrived to collect her mother she noticed that Mrs Y had bruising to both hands, which she alleged had been caused by an assault by a fellow patient. The nursing staff had not seen the incident, although shouting had been heard in the day room during "handover" the previous evening, and they had not noticed Mrs Y's injuries. An x-ray of Mrs Y's right hand the following day could not rule out an undisplaced fracture of two fingers.

The Ombudsman partly upheld the complaint. He expressed concern over staffing levels which meant patients were unsupervised during a handover period, and about the quality of record-keeping – in particular with regard to Mrs Y's behaviour during the day in question, the incident itself and the examination of Mrs Y when the injury was drawn to the attention of nursing staff. He recommended that the LHB apologise to Ms X for the shortcomings identified, review its staffing levels and procedures for handover periods and remind staff of the importance of comprehensive and accurate records. The LHB accepted and agreed to implement the recommendations.

Case reference 201000575

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

Mr C complained about the standard of post surgical in-patient care afforded to him by the former Trust and about the delay in dealing with his complaints, including a delay in replying to his advocate. Mr C complained in particular that: following spinal surgery he suffered unbearable pain which had continued for some months afterwards, and no one had told him why; staff failed to pay attention to his pain whilst he was in hospital; the Consultant did not personally review him; he was discharged too early whilst still in pain; and inappropriate transport was provided to take him home (in light of his having undergone spinal surgery) such that he suffered further pain and discomfort.

Following advice from the Ombudsman's clinical advisers, the complaint was upheld in part. Whilst there was evidence of efforts made to control Mr C's pain, there were uncompleted pain chart assessments for a two day period so that it was possible Mr C's pain complaints went unheeded. However, the investigation found that it was impossible to know why Mr C had suffered the level of post surgical pain he did as there were a number of potential contributory factors. There was no evidence of any untoward surgical event. There was no clinical reason for the Consultant to personally review Mr C as other clinical staff were in place to do so, there was no evidence either of his being unfit for discharge. It was not a requirement to have in place a formal policy on the type of hospital patient transport and it was impossible to know what information had been given at the time of booking it (although the UHB had since introduced a transport booking form with specific guidance and to facilitate requests.) The UHB had already apologised for the poor complaint handling and Mr C's distress, and the Ombudsman recommended it also apologise to the advocate for failing to reply to her in a timely way. It was also recommended that the UHB reinforce to staff the importance of recording and the proper completion of relevant documentation.

Case reference 201000328

February 2011 – Clinical treatment in hospital – Hywel Dda NHS Trust (now Hywel Dda Health Board)

A woman admitted to Withybush Hospital in November 2008 with shortness of breath and chest pain complained that her condition was not properly diagnosed in hospital and that she was discharged before tests (later carried out when she was an outpatient) were performed. She also maintained that the dosage of medication prescribed on discharge was inappropriate and that her condition had warranted an earlier referral to a heart specialist.

After taking clinical advice the Ombudsman found that the woman had been treated reasonably but that earlier referral to a cardiologist for possible cardioversion should have been considered. He considered that the arrangements for follow-up tests and review were not clearly explained to her but concluded that although the medication prescribed on her discharge subsequently needed review it had been appropriately prescribed. The Ombudsman also found some failings in the former Trust's handling of the woman's complaint. Hywel Dda Health Board agreed to consider when cardioversion might be used and to apologise to the complainant for the failings identified by the Ombudsman.

Case reference 200900849

February 2011 – Appointments/admissions/discharge and transfer procedures – Betsi Cadwaladr University Health Board

Mr A suffers from, amongst other things, Addison's disease and insulin dependent diabetes mellitus. He complained about the delay in receiving dental treatment because of health professionals' concerns about potential complications caused by his condition. Some of the clinicians who saw Mr A believed that additional precautions were necessary, and this meant that Mr A was seen first at the Royal Alexandra Hospital and subsequently at Ysbyty Glan Clwyd. This led to a delay in Mr A receiving treatment, which was eventually carried out uneventfully with no supplementation of his existing medication.

The Ombudsman partly upheld the complaint. Although it was regrettable that not all the clinicians were familiar with current advice regarding treatment of such patients, he was not critical of some being over-cautious. He did not uphold the complaint regarding the quality of treatment which Mr A received. However, he found that Mr A had been given inaccurate information on when he might expect to receive treatment, and upheld Mr A's complaint in this respect. He recommended that the LHB apologise to Mr A, and ensure that accurate information is provided to patients in future. He suggested that the LHB should review its procedures for treating medically compromised patients. The LHB agreed to implement the recommendations.

Case reference 201000622

February 2011 – Clinical treatment in hospital – Cwm Taf Local Health Board

On 9 April 2010 the Ombudsman received a complaint against Cwm Taf Local Health Board ("the LHB") from Mrs C about out-patient treatment at the Podiatry department of the Royal Glamorgan Hospital and about the way her complaint had been dealt with by the former Cwm Taf NHS Trust and the LHB. Mrs C said that she was concerned that she may have been misdiagnosed with arthritis in her left knee in 2005. She said that as a result of being prescribed shoe wedges to treat that condition she then experienced swelling and pain in her right ankle. She was also concerned that poor communication between departments caused delays and problems with her treatment and that there were also delays when her complaint was dealt with by the LHB.

The Ombudsman found that there was no evidence that she had been misdiagnosed in 2005 or that the prescribed shoe wedges had caused the swelling and pain in her right ankle. This part of the complaint was therefore not upheld. The Ombudsman upheld Mrs C's complaint that there was poor communication between departments and that this caused delays in her treatment (however, the Ombudsman did not find any evidence that this had an impact on her condition). The Ombudsman also upheld Mrs C's complaint that there were delays when the Trust and LHB dealt with her complaint.

The Ombudsman made a number of recommendations including that the LHB should provide an unreserved apology to Mrs C for the loss of the notes relating to her Podiatry treatment and the failure to advise her of this loss at an earlier date; for giving her the impression that the review of systems was anything more than a verbal discussion between the departments involved and also for the unacceptable delays that occurred in dealing with her complaint.

The Ombudsman recommended that the LHB pay Mrs C the sum of £250 in recognition of the time and trouble in pursuing her complaint and that this payment, the apologies and an update on the action agreed to by the Head of Nursing on 6 July 2010 are given to Mrs C within 1 month of the receipt of the report.

Case reference 201000072

February 2011 – Continuing Care – Gwynedd Local Health Board (now Betsi Cadwaladr University Health Board)

Miss B complained about the manner in which Gwynedd Local Health Board ("the LHB") considered Mrs B's eligibility for NHS funded continuing care ("NHSFCC"). Miss B complained that the LHB turned down Mrs B's applications for NHSFCC and in reaching its decisions, failed to understand Welsh Assembly Guidelines and relevant case law. Miss B complained that it took from April 2006 to April 2007 to have an Independent Review (IR). Further, following the Panel's recommendation that Mrs B met the criteria for NHSFCC, there was a delay in putting together a sensible care plan, and obtaining costs to facilitate Mrs B's discharge home. In addition, Miss B complained that the LHB failed to obtain costs in respect of the care package from providers other than day agencies. Finally, Miss B complained that the LHB failed to take into account the wishes of Mrs B to go home. The Ombudsman's investigation found that the Continuing Health Care Panel failed to take the Multi Disciplinary Team assessments into account and failed to act in accordance with its policy when reaching its decision that Mrs B was not eligible for NHSFCC. The Ombudsman raised concerns that the previous flawed decisions were most likely to have been a result of not fully understanding the requirements to consider the overall "primary need for healthcare test" and the "quantity test" as arising from relevant case law.

The Ombudsman criticised the LHB for failing to draw attention in its early decision letters to the option for Miss B to request an Independent Review but found no evidence that the LHB failed to convene a Panel between the periods April 2006 to 30 April 2007. Furthermore, the Ombudsman found that the LHB had exercised its discretion in reaching its decision not to obtain costs from providers other than day agencies. The Ombudsman found no evidence that the LHB had expressed disagreement with the home being the setting where care is provided and it had therefore taken Mrs B's wishes to go home into account. Finally, the Ombudsman criticised the LHB for not having clear guidance which outlined the process and timescales for agreeing plans for continuing care at home, but found that the LHB had requested a care package and costings from four providers. The Ombudsman accepted that disagreement between the LHB and Miss B regarding the preferred choice of care, had caused some delay in putting together a care package and costings to which both parties agreed.

The Ombudsman made a number of recommendations including that the LHB apologise to Miss B for the shortcomings identified; and carry out a review of its policy and guidance to ensure it incorporates matters relating to the practicalities of enabling discharge home.

Case reference 200900293

January 2011 – Clinical treatment outside hospital – Cwm Taf Local Health Board

Mr W complained that a GP working for Cwm Taf LHB failed to respond appropriately to his late mother's symptoms, including thigh pain, during her treatment in 2008. Eventually, the GP arranged admission for Mrs W to hospital, where she was diagnosed with lung cancer which had spread to her thigh. She sadly died soon after.

The Ombudsman upheld the complaint. He found that Mrs W's presentation of symptoms was difficult to diagnose. However, he concluded that the GP should have referred Mrs W to a specialist for suspected cancer, in line with guidelines, over one month earlier than Mrs W was admitted to hospital. The Ombudsman found that the GP missed three opportunities to make that decision. In doing so, he acknowledged that Mrs W's symptoms meant that the GP's failure to refer was not a serious clinical error. He also noted that, although an earlier referral may have alleviated some of Mrs W's pain, the sad outcome was inevitable even with a prompt referral. The Ombudsman recommended that the LHB pay Mr W £600 as redress for additional distress that an earlier referral would have minimised. He also recommended that the GP discuss the issue with her appraiser to ensure that lessons are fully learned. The LHB accepted the Ombudsman's recommendations.

Case reference 201000362

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

Mrs B complained about the standard of care and treatment offered to her husband by a hospital which is managed by Aneurin Bevan Health Board (the Health Board). Mrs B complained that Mr B was placed in an inappropriate care setting and procedures should have been in place to deal with Mr B's physical care needs and not just his dementia. Mrs B also complained about the nursing staff's management of Mr B's care needs when it came to preventing pressure ulcers. Mrs B said that she believed that the failure to prevent ulcers had later necessitated his left leg being amputated above the knee.

The Ombudsman's investigation concluded that Mr B's lack of mobility, difficulty in eating and incontinence, together with his age, made it more likely that pressure ulcers would develop. He also highlighted that a specific care plan for this was not drawn up on admission, and specialist advice was not sought from the wound care team. The Investigation found that Mr B was placed in a poor care setting which had impacted at various points the care he received. The investigation also revealed that the standard of record-keeping and assessment was poor. Mrs B's complaint was upheld.

Amongst the recommendations the Ombudsman made were that the Health Board should apologise to Mrs B for the failings in relation to Mr B identified and pay Mrs B £750 to reflect the additional anxiety and stress that was caused both to her and Mr B. Finally, the Health Board should review its systems to ensure that the quality of record keeping meets the standards outlined by the Nursing and Midwifery Council.

Case reference 200902101

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

Mr A complained about failings in the care of his late wife at Ysbyty Gwynedd in the days leading up to her death in December 2007. Mrs A suffered from multiple medical problems, including chronic kidney disease, heart problems, diabetes, deafness and asthma. She was admitted to hospital as an emergency following a gradual deterioration in her condition over the previous week. Mr A said that there had been inadequate monitoring/control of Mrs A's fluid levels, a failure to ensure Mrs A was eating properly and reviewed by a diabetic nurse, a delay in review by a Cardiologist, a failure in communication with the family regarding a DNR decision not to resuscitate, and the lack of privacy in the High Dependency Unit ("HDU") at the time of Mrs A's death. Mr A also complained that the LHB had breached confidentiality on two occasions during the consideration of his complaint, by providing details of the complaint and his wife's medical history to persons not employed by the LHB.

The Ombudsman upheld Mr A's complaint in respect of the failings about which Mr A complained and which had been previously accepted by the LHB. He concluded that the LHB's initial response to the complaint had been superficial, and that it had only accepted its failings when Mr A had pursued his complaint at length. Although the Ombudsman welcomed the steps already taken to improve patient care, he expressed concern about delays which had occurred in the LHB's consideration of Mr A's complaint. He also upheld Mr A's complaint regarding breaches of confidentiality by the LHB. He recommended that the LHB should apologise to Mr A for its handling of his complaint and the breaches of confidentiality; it should also make amendments to the action plan already developed in response to Mr A's complaint to adequately deal with the failings which had been identified. The LHB accepted the Ombudsman's findings and agreed to implement the report's recommendations.

Case reference 200901933

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

Mrs Y complained about the care provided to her father, Mr X, whilst he was a patient at hospital. Mr X had been admitted on 6 April 2008 with a history of weight loss, poor appetite and dehydration. At the A&E Department Mr X was noted to be short of breath and slightly confused, he was transferred to the Acute Medical Unit (AMU) and then on 7 April to Ward 11 (a Care of the Elderly Ward). Sadly, Mr X's condition deteriorated and he died at 1.25am on 9 April. Mrs Y complained that nursing staff had failed to adequately monitor and record observations in the 12 hours preceding Mr X's death and that as a result staff were not aware of his deterioration. She considered that this did not enable the family to be notified and to be with Mr X just before or at the time of his death.

The hospital was at the time managed by the North Wales NHS Trust ("the Trust"), whose responsibilities have now been taken over by the Betsi Cadwaladr University Health Board ("the Health Board").

The Ombudsman upheld the complaint. The Ombudsman concluded that nursing staff had failed to carry out reasonable observations and failed to act on the observations that had been undertaken in accordance with the MEWS chart (Modified Early Warning System which measures the degree of critical illness), which indicated that there had been a deterioration in Mr X's condition.

The Ombudsman recommended that the Health Board apologise to Mrs Y and her family for the identified shortcomings and to remind staff of the importance of regular monitoring, observations and record-keeping. The Ombudsman also recommended that the Health Board ensure that its staff acts in accordance with the MEWS chart that the hospital already had in place.

Case reference 200901463

January 2011 – Clinical treatment in hospital – Gwent Healthcare NHS Trust (now Betsi Cadwaladr University Health Board)

Messrs J complained about the care and treatment given to their mother, Mrs J, who sadly died at the Royal Gwent hospital in October 2006. They complained that clinicians failed to diagnose and treat caecal volvulus (twisting of part of the bowel); that clinicians did not take account of Mrs J's previous medical history; that she was not seen by a senior doctor when her condition deteriorated; that there was no exploratory surgery or proper palliative care/pain management; and that she was not admitted to ICU.

The Ombudsman upheld aspects of the complaint. He found that additional diagnostic steps (through a CT scan) could have been undertaken and that surgical advice should have been sought, although these may not have changed the outcome. He concluded that the junior doctor who saw Mrs J on the day she died should have sought senior clinical support; and that Mrs J was not provided with appropriate pain relief at the end of her life. The Ombudsman made a range of recommendations with a view to improving patient care in the future.

Case reference 200900830

January 2011 – Clinical treatment in hospital – Cwm Taf Local Health Board

Mr B complained that, following an operation to remove bowel cancer, he was discharged from hospital when not well enough and subsequently returned to hospital three days later as an emergency patient, due to a complication related to his surgery. Mr B complained that he should not have been discharged so soon after his original surgery and that clinicians had missed signs that all was not well with his recovery from the surgery. Mr B complained that had he not been discharged inappropriately he would not have suffered the pain, distress and suffering which arose out of his subsequent complications and emergency surgery.

The Ombudsman found that tests carried out on Mr B following the original surgery, which gave an early indication that complications had arisen, were not given due attention by clinical staff. The Ombudsman found that had these results been appropriately considered, it was likely that Mr B's surgical complications would have been identified during his original hospital admission, he would not have been discharged and there would have been earlier surgical intervention to address the complications he experienced.

The Ombudsman recommended that the Health Board should apologise to Mr B and pay the sum of £1000 in recognition of the failings identified and in respect of the pain and distress he suffered as a result. The Ombudsman also recommended that the Health Board should review the failure to properly consider Mr B's test results and should consider issuing guidance to its staff in respect of post-operative monitoring.

Case reference 201000750

January 2011 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board (ABM UHB) and GP in ABM UHB area

Mr R complained about his GP practice and his local hospital, regarding the monitoring and management of his treatment under a 'shared care' agreement between the two authorities, the prescription of his medication and with regard to his removal from the GP practice's patient list.

The Ombudsman found that there had been a number of breakdowns in communication on the part of the GP practice and the hospital, which resulted in distress and inconvenience to Mr R, due to uncertainty as to who was monitoring his care and in respect of the availability of his prescription medication. The Ombudsman also found that Mr R's removal from the GP practice's patient list had not been administered wholly in accordance with the relevant guidance.

The Ombudsman recommended that both authorities should apologise to Mr R for the failings identified and that various reviews should be carried out to prevent such failings occurring again.

Case reference 201000204 & 201000176

January 2011 – Clinical treatment in hospital – Powys Local Health Board (now Powys Teaching Health Board)

Mrs T's substantive complaint centred on the management and care provided to her father, Mr S, at the Brecon War Memorial Hospital ("the Hospital"). One of the areas that she highlighted was the lack of post-operative monitoring of her father during the night following his operation to relieve a blockage in his gullet on 5 November 2008. She highlighted that on the morning of the 6 November 2008, her father had fallen out of bed and died shortly afterwards. Mrs T was also dissatisfied that Mr A (whom she referred to as her father's handyman and who visited her father at the Hospital), had been informed of her father's death before her. She was also dissatisfied that Mr A had been allowed to view her late father's body without her permission.

The investigation identified shortcomings in the care provided to Mr S and inadequacies in record keeping. The Ombudsman was also critical of the way the LHB had dealt with Mrs T's complaint. The Ombudsman concluded that there had been service failings in these areas and upheld Mrs T's complaint.

In relation to other aspects of Mrs T's complaint, the Ombudsman noted that the LHB had apologised for its failure to adhere to its Mortuary Policy and acknowledged that Mr A should not have been allowed to see Mr S's body without the next of kin's express permission. He concurred with the LHB in finding shortcomings in the LHB's investigation of the incident.

The Ombudsman felt (given the circumstances) that he was not in a position to find service failings in relation to Mr A being informed of Mr S's death ahead of Mrs T. However, he indicated that had there been better monitoring of Mr S before he fell, changes in Mr S's condition might have been detected sooner and the family notified earlier; possibly preventing an occurrence of the scenario with Mr A.

The Ombudsman recommended that the Health Board apologise to Mrs T and make a payment to her of £250 in recognition of the distress and inconvenience caused to her by the way it had considered her complaint. The Health Board was also asked to produce an action plan setting how it intended to address the shortcomings that had been identified in the report.

Case reference 200900775

January 2011 – Clinical treatment in hospital – Cwm Taf Health Board

Ms E complained about the standard of care and treatment given to her late mother, Mrs E, while she was a patient at Prince Charles Hospital in Merthyr Tydfil in May 2009. In particular, Ms E complained that there was a delay in dealing with her mother's bowel problem; that staff did not use appropriate techniques when moving Mrs E; that more weight should have been given to Mrs E's very frail condition when prioritising her care; and about the attitude of some members of staff.

The Ombudsman partly upheld the complaint about Mrs E's care and treatment as certain observations appeared not to have been acted on. However, he found it was reasonable that a manual bowel evacuation was not done sooner than it was. The Ombudsman also partly upheld the complaint about the weight given to Mrs E's frail condition. He made no finding on the complaints about staff using inappropriate manual handling techniques and about the attitude of some members of staff as in both instances it was Ms E's word against that of the staff. The Ombudsman recommended that the Health Board should apologise to Ms E for the failings identified and he also made some procedural recommendations. The Health Board accepted the Ombudsman's recommendations.

Case reference 201000171

Not Upheld

March 2011 - Clinical treatment in hospital – GP in Cardiff and Vale University Health Board area

Mr B's wife died of cancer in November 2008. She had seen her GP in September and October with worsening symptoms. Mr B accepted that his wife could not have been cured but he complained that the GP had been too slow in acting on his wife's symptoms and failed to see that she was seriously ill.

The Ombudsman did not uphold the complaint and concluding that there had been no delays or failings in Mrs B's care by the GP practice. The Ombudsman was, however, concerned about poor record keeping at the GP practice and asked the practice to consider what improvements might be made.

Case reference 201000058

March 2011 – Clinical treatment in hospitals – Abertawe Bro Morgannwg University Health Board

Mrs F complained about the diagnosis and treatment offered to her by the NHS Consultant Orthopaedic Surgeon when she saw her in relation to the treatment of her foot and ankle problems in November 2007. In particular, Mrs F complained that the NHS Consultant Orthopaedic Surgeon misdiagnosed her condition and therefore offered her a drastic and irreversible treatment option. Mrs F said that as a consequence of this misdiagnosis, she was required to incur the costs of having treatment undertaken privately, when it should have been offered to her on the NHS.

Having sought clinical advice from two of the Ombudsman's professional advisers, the investigation found that the diagnoses provided by the NHS Consultant Orthopaedic Surgeon and the private Consultant were essentially the same. The investigation also found that while the treatment recommended by the NHS Consultant Orthopaedic Surgeon differed from that offered by the private Consultant, this did not indicate that either the diagnosis provided or the treatment offered to Mrs F on the NHS were incorrect or unreasonable. Also, there was no evidence to suggest that Mrs F approached the NHS Consultant Orthopaedic Surgeon prior to having the private treatment undertaken to discuss the surgery that had been offered to her by the private Consultant and to provide the Health Board with an opportunity to consider whether to offer Mrs F the same surgery on the NHS as was suggested by the private Consultant. Therefore, the Ombudsman did not uphold the complaint.

Case reference 201001841

March 2011 – Appointments, admissions, discharge and transfer procedures – Velindre NHS Trust, GPs in Aneurin Bevan Health Board area, Gwent Healthcare NHS Trust (now Aneurin Bevan Health Board)

Mr D complained about the care of his late mother ("Mrs D") by the Trust, Practice, and Board, before her death primarily from gynaecological cancer, and a terminal heart condition. In particular, Mr D complained as against each (both jointly and severally) that they had: failed to share information with each other regarding Mrs D's health including when she was discharged / re admitted; those communication failings resulted in Mrs D being unable to die at home, as she had expressly wished; and they had failed / delayed in admitting her when she was very unwell in her final days before she passed away at the Board's hospital.

In addition, Mr D complained that the Trust had subjected his mother to exhausting radiotherapy treatment and had discharged her at weekends during treatment contributing to her discomfort, as well as failing to share with him (or Mrs D) sufficient information about her terminal condition. As against the Practice, Mr D additionally complained that it took too long to respond to his formal complaint (made after his mother's death). Additional complaints against the Board related to Mrs D's re-admission to the Medical Admissions Unit ("MAU"), as opposed to a hospital ward, when she had only been discharged 24 hours earlier, and about its management of Mrs D's gynaecological care at initial diagnosis. A pathology sample had initially been reported as borderline cancer, and Mrs D clinically managed accordingly, but, four years later, when the sample was reviewed against a current sample (2 months before Mrs D's died), it was found to also have been of a high grade tumour.

Following advice from the Ombudsman's clinical advisers, all complaints against the Trust were not upheld. There was evidence of communication with the Practice on discharge from its care, and with Mr D and his mother (whilst an inpatient) about the palliative nature of the care it was affording. She had expressly wanted to go home at weekends. The majority of complaints against the Practice were not upheld. There was evidence of a good standard of management of Mrs D's conditions and attempts made to gain her swift admission when she was very unwell. However, the complaint about the Practice's complaint handling was upheld, as a delay of 4 months in responding was clearly unacceptable. In relation to the Board, the complaint about ineffective communication with the Practice on Mrs D's discharge was upheld as there was no evidence of a hospital discharge summary being sent (or given to Mrs D as the patient) in the clinical records, or of its receipt in the Practice records. That would not, however, have affected the need for Mrs D's readmission the following day, and her clinical management was not compromised by readmission to the MAU (being usual admission practice), so that aspect was not upheld.

No definitive finding could be made about the complaint concerning Mrs D's initial gynaecological diagnosis. It was impossible to know whether the different conclusions reached about the samples may have affected Mrs D's chances of cancer free survival (in that she could have undergone chemotherapy four years earlier). It was impossible to say with certainty whether the sample ought to have been reported differently at the time. There were also no minutes for the MDT2 meetings, to evidence discussion, which was itself a failing. The different conclusions about the sample had also not been shared with Mr or Mrs D.

The Ombudsman made the following recommendations, which were all agreed to: that the Practice apologise to Mr D for its complaint handling failings; that the Board apologise to Mr D for the communication failings including for not sharing with him the changed diagnosis; and that the Board undertake a critical governance review (as a Root Cause Analysis) in relation to the first pathology finding and Mrs D's diagnosis, to include obtaining an expert pathology opinion of the sample.

Case references 200902372, 200902373 & 200902334

March 2011 – Clinical treatment outside hospital – GP in Aneurin Bevan Health Board area

Mr R complained that a receptionist at his brother's GP practice refused to arrange a home visit by a GP to see his brother (Mr S) who was having difficulty breathing. However Mr S was able, with the assistance of Mr R, to attend the GP practice. During the subsequent consultation the GP, Dr T determined that Mr S should be admitted to the local acute hospital. However Mr S refused admission but agreed instead to attend a local community hospital for a scan and assessment at an outpatient clinic. Mr R took Mr S to the community hospital in his car. Shortly after arrival at the community hospital Mr S collapsed and needed to be resuscitated before being transferred to the acute hospital. Mr R complained to the Ombudsman that the GP should have arranged for an ambulance to transfer his brother to the outpatient clinic.

The Ombudsman found that since Mr S had been prepared, and was able, to attend the GP practice with the assistance of his brother, it was appropriate for him to be offered an early clinic appointment. The Ombudsman's clinical advisers also considered that Dr T's assessment that Mr S was clinically stable when he was seen meant that it was not unreasonable for Mr S to be transported to the outpatient clinic by private vehicle. Accordingly the complaint was not upheld.

Case reference 200902204

March 2011 – Clinical treatment outside hospital – GP in Cardiff and Vale University Health Board area

Mr B's wife died of cancer in November 2008. She had seen her GP in September and October with worsening symptoms. Mr B accepted that his wife could not have been cured but he complained that the GP had been too slow in acting on his wife's symptoms and failed to see that she was seriously ill.

The Ombudsman did not uphold the complaint, concluding that there had been no delays or failings in Mrs B's care by the GP practice. The Ombudsman was, however, concerned about poor record keeping at the GP practice and asked the practice to consider what improvements might be made.

Case reference 200800058

February 2011 – Clinical treatment in hospital – Powys Teaching Health Board

Mr and Mrs W complained that Powys Teaching LHB (the "LHB") failed to make an assessment of their son's sensory integration needs and failed to inform them that it did not use sensory integration techniques in making assessments or providing therapy services. They complained further that the LHB's occupational therapist gave inappropriate and/or misleading evidence to the Special Educational Needs Tribunal ("SENTW") which heard their appeal in respect of their son's special educational needs. Finally they complained that the LHB's response was unsatisfactory.

Their complaint was not upheld. Advice from a specialist occupational therapist confirmed that the LHB's acceptance of the referral of the complainants' son's case was appropriate. In particular, the information which accompanied the referral of their son's case for an assessment did not explain the recommendation that he required a "daily sensory diet". Nor was the conclusion that their son might experience sensory difficulties substantiated. Furthermore, the LHB's assessment itself was conducted in an appropriate manner by an occupational therapist who was qualified and sufficiently experienced. The occupational therapist had also expressed views within the scope of his own practice when he provided comments on reports of therapy assessments commissioned by Mr and Mrs W for the SENTW proceedings. Finally, the investigation concluded that the LHB's response to Mr and Mrs W's complaint was adequate.

Case reference 200901981

February 2011 – Clinical treatment outside hospital – GP in Betsi Cadwaladr University Health Board area

Mrs R complained that GPs failed to deal promptly with her husband's, Mr R's, symptoms and deteriorating health, particularly in light of his history of prostate cancer. Mr R sadly died at the end of December 2008. Mrs R provided a statement made by her husband in which he said that despite visiting the GP practice on many occasions, he was repeatedly told that his symptoms related to pneumonia and would take time to clear. The GP practice provided an account of each of the consultations with Mr R.

Having taken independent clinical advice, the Ombudsman did not uphold the complaint, concluding that the GPs' actions were reasonable.

Case reference 200900801

February 2011 – Clinical treatment in hospital – Cardiff and Vale NHS Trust (now Cardiff and Vale University Health Board)

Mrs S complained about antenatal care provided by Cardiff & Vale University Health Board (formerly Cardiff & Vale NHS Trust). She endured severe pain during her second pregnancy in 2006/2007, and has suffered a plethora of serious health problems since. She complained that a condition called symphysis pubis dysfunction (SPD; a misalignment of the pelvis) was not diagnosed during the pregnancy, and that the severity of the condition meant that the baby should have been delivered by caesarean section, not through a natural birth.

The Ombudsman did not uphold the complaint, having taken clinical advice. He found that Mrs S's long-standing history of back pain, which combined with another condition, hydronephrosis (where urine cannot flow properly out of the kidney causing swelling of the kidney), accounted for her symptoms. Even had SPD been diagnosed it was not necessarily an indicator for a caesarean section, and a natural birth was appropriate. However, the Ombudsman found that there had been poor bladder management following the birth, and that the Health Board had no policy in place at the time on bladder management following an epidural. The Ombudsman recommended that the Health Board apologise to Mrs S for this, and also put in place a protocol for this.

Case reference 200900783

February 2011 – Clinical treatment in hospital – Cwm Taf Health Board

Mrs G complained about the care and treatment that her grandson Mr B received when he attended the Accident & Emergency Department at Prince Charles Hospital in December 2008. Mrs G complained that the clinicians acted inappropriately in failing to diagnose her grandson's Deep Vein Thrombosis (DVT). In particular, she was of the view that had her grandson's own doctor not acted so quickly, her grandson could have deteriorated and this may have led to a blood clot travelling around his body, resulting in a more serious or potentially fatal outcome. She questioned why a scan was not carried out when her grandson first arrived at the Hospital or at a later date. Mrs G also complained that her grandson's family history was not properly considered by the clinicians when making their diagnosis.

Having sought clinical advice, the investigation found that the diagnosis that there was no DVT when Mrs G's grandson attended in December was not unreasonable. The Ombudsman is unable to use the hindsight and knowledge of later events when considering the appropriateness of a diagnosis. There was no evidence to conclude that the initial non-diagnosis of DVT in Mrs G's grandson's case would have potentially led to a more serious outcome. Also, there was no evidence to conclude that further action, in particular a scan, should have been undertaken by the clinicians. The Ombudsman found that accepted guidelines were followed by the clinicians when deciding that Mrs G's grandson should not receive a scan when he was first admitted and the evidence confirmed that a scan was carried out at a later date, due to his worsening symptoms and increased likelihood of DVT. Finally, documentation showed that a reasonable assessment of Mrs G's grandson's history was undertaken by the clinicians. Therefore, the Ombudsman did not uphold the complaint.

Case reference 201001301

January 2011 – Clinical treatment outside hospital – Betsi Cadwaladr University Health Board

At the time of the complaint Mrs A's GP surgery was being run by the LHB. Mrs A telephoned the surgery at 8.20am to make an appointment for her son, B, aged 2, as he had developed a rash. As appointments could not be made until 8.30 she was advised to telephone again then; when she did so she was given an appointment for 10.20am. The doctor concluded that B's rash was caused by an insect bite or contact with plants in the garden. Later that day B was taken to hospital where he was diagnosed with a viral infection. Mrs A believed that she should have been advised to take B to the surgery immediately and also that the doctor had failed to examine him properly.

The Ombudsman, with advice from a clinical adviser, found that Mrs A's telephone calls were handled appropriately – the acting practice manager to whom Mrs A spoke did not understand that Mrs A considered the situation to be urgent. He concluded that the doctor acted reasonably, and his diagnosis was consistent with the symptoms and signs recorded. He did not uphold the complaint.

Case reference 201000821

January 2011 – Appointments/admissions/discharge and transfer procedures – Cardiff and Vale University Health Board

The complainant was unhappy with the overall treatment given to her daughter by the Mental Health Service of the former Cardiff and Vale NHS Trust. Her daughter had suffered with depression and following a period of self harming took her own life. She was particularly concerned that her daughter was not detained in hospital following an incident at home and subsequent admission to the Accident and Emergency Unit of the University Hospital Wales. She also considered that the outcome might have been different if the family had been more involved.

The Ombudsman did not uphold the complaint. Based on the appropriate clinical advice he found that the daughter's care was not unreasonable. Also the assessment carried out on her admission to hospital was reasonable and the decision that she should not be detained was taken after consultation with a more senior colleague. An appointment for longer term treatment as an outpatient had also been made. It was also found that the family had been appropriately involved and that any further involvement would not necessarily have altered the outcome.

Case reference 200901806

Planning and Building Control Summaries

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

March 2011 – Handling of planning application – Isle of Anglesey County Council

Mr W complained that after he sought planning permission for the use of his site for commercial storage purposes, the Council wrongly granted planning permission for raising the height of a boundary wall on a neighbouring site which detrimentally affected visibility at the access to the trading estate on which both sites were located. He complained further that the Council failed to secure a reduction in the height of the wall. As a consequence, he was unable to implement his own permission which had been granted subject to a condition preventing the use of the site until the height of the wall was reduced. He also suffered financial losses and claimed that his costs of developing the site following the eventual reduction in the height of wall were significantly greater than they would have been had he been able to develop the site following the grant of an unrestricted planning permission in a timely manner.

His complaint was upheld. The plans of the proposed development on the neighbouring site showed some information regarding the proposal to raise the height of the wall, but the Council failed to recognise this and/or failed to obtain further information from the applicant. The raised height of the boundary wall adjacent to the access to the trading estate was detrimental to highway safety. The evidence showed that the Council had failed subsequently to address the issue and to respond satisfactorily to correspondence from Mr W's agent. Eventually, and after Mr W complained to me, the Council secured the reduction in the height of the wall some 2 years later.

The Council was recommended to reimburse Mr W's company its financial losses (assessed at £30,626) by means of an initial payment of £20,000, and the balance within 12 months of the commencement of trading on the site, as adjusted if necessary in the light of any significant new information emerging regarding the precise extent of the assessed losses. The Council was further recommended to pay his Company a sum equivalent to the difference between the estimated costs of developing the site had planning permission been granted in a timely manner in 2008 and the sums actually paid when he does so, and a contribution of £1500 towards Mr W's costs in pursuing the complaint. Finally, the Council was recommended to draw the Ombudsman's report to the attention of the Commissioners (appointed by the Welsh Assembly Government in March 2011 to take over the Council's executive powers).

Case reference 200901501

Upheld

March 2011 – Planning matters – Carmarthenshire County Council

Mrs T ran a farm and on her boundary a piecemeal development of training facilities and a coach depot has been established on the site of a former colliery. She complained that the coach company has been relocated to an area of that site for which it has not got planning permission. She said that the Council allowed the area to be developed despite her reports of the commencement of the construction of unauthorised structures in June 2008. In November 2008, permission was refused for the relocation. Nevertheless, the coach depot remained in position and in operation. The paramount concern for Mrs T was the surface and foul water emanating from the site. She produced an expert report to prove that her watercourses had been polluted and a further study to recommend methods to drain the land effectively. The latter report also provided evidence to prove that a 'preliminary' report submitted by the developer was based on fallacious assumptions on surface water run-off. Mrs T complained that her reports were ignored. Instead, two planning reports assessing applications submitted to retain the development recommended approval whilst not resolving the drainage problems and relying on the original 'preliminary' report.

The first application was refused in November 2009 on drainage and highway grounds. An appeal was submitted against the decision. An enforcement notice was then served on the developer and site owner which required cessation of the use of the land as planning conditions could not overcome the in principle policy objections. An appeal was again submitted and a date was set by the Planning Inspectorate to hear both matters. Mrs T complained that instead of allowing the Planning Inspectorate to adjudicate, the Council then approved a further, identical application due to the removal of highway objections and, it said, the receipt of considerably greater drainage detail. She said that the highway objections were withdrawn due to false claims made by the developer on the extent of site ownership, which were not investigated by the Council. As a result, a proposed Section 106 Agreement felt necessary to implement improved visibility splays had not been signed and the planning permission cannot be issued. The present unsatisfactory situation therefore still stands. Mrs T also questioned the contention that the drainage scheme lodged is satisfactory. The surface water system proposed is the same as previously submitted. She was also concerned that the comments made by the Environment Agency as consultee were misrepresented in the planning report presented to the Committee.

The Council said that planning officers had worked extremely hard to try to resolve this complex planning case. The area has an industrial history and is now a brownfield site suitable for a business providing much needed employment for local people. The site, as a whole, could already accommodate 10 buses as a result of previous planning consents. It had followed guidance issued by the Welsh Assembly Government in its approach to enforcement matters. Enforcement action was indeed taken promptly following the planning decision made in November 2009. In addition to enforcement action, proceedings were also issued for breach of Building Regulations and the other breaches of the Building Act. The Public Health Section is involved closely in monitoring any reports of pollution and the Council said that only two minor incidents of effluent discharge have been evident. Although a date had been set for the public inquiry to hear the two appeals, the Council had a duty to determine all planning applications and once it felt it had sufficient detail to make an informed decision, it had no alternative but to determine the second application, which it did on

the 1 April 2010. It was entirely appropriate to rely on what the applicant was saying with regard to land ownership in the preparation of the planning report and then to make relevant enquiries once the application had been approved. If it had been the case that the proposed Section 106 Agreement to improve visibility splays cannot be executed, then the consent would not be issued and enforcement action would follow.

The Ombudsman found that whilst acknowledging the industrial history of the site and the need for dialogue with the developer before enforcement action is considered, it was questionable whether the enforcement regime in this instance was timely and effective, evident by the fact that the planning situation has still to be resolved. There was also a question of consistency in the Council's approach. The service of an enforcement notice was thought expedient due to the fact that development was contrary to policies contained in the Unitary Development Plan, sandwiched between two reports which recommended approval because the development complied with policy. If it was in a position to do so, the Council was under a duty to determine the second planning application despite the fact that a date had been set for the public inquiry into the appeals. The Council also followed normal procedure in accepting the applicant's claim on land ownership and making a planning decision before confirming ownership details.

Nevertheless, given the long planning history and the importance of highway issues in the eventual decision, ownership enquiries made before the application was submitted to Committee might have avoided the additional 12 month delay which has occurred. The Section 106 Agreement has yet to be executed. The Ombudsman recommended that the issue be resolved promptly. If the agreement can be signed and the consent issued then it should be done conditional on a suitable surface water drainage scheme being submitted for approval. If not, enforcement action should be considered speedily. In recognition of the Council's failings and the stress and frustration caused by them, the Ombudsman recommended the Council pay Mrs T the sum of £1,500 to include a contribution to the considerable cost she incurred in trying to protect her land by seeking legal assistance and expert reports.

Case reference 200900778

February 2011 – Handling of planning application – Monmouthshire County Council and Brecon Beacons National Park Authority

Mrs H complained about the delay in handling her application for planning permission for an off-road parking area at her property. This would require some excavation work and the creation of a new access onto the highway. After waiting for months, the Authority rejected the application on the grounds of insufficient information.

The Ombudsman, having taken advice from his planning adviser, found that whilst the process had been lengthy, this was not the fault of the Authority and the decision it had reached was not unreasonable. He therefore did not uphold this part of the complaint. The Planning Authority had a statutory duty to consult other bodies about the proposals, one of these being the Council's Highways Department. The Ombudsman found that the Council's Highways Department was tardy in providing its responses to the statutory consultation. He also noted that, whilst there is no guidance as to how much assistance should be given to applicants about what missing information is required, in the circumstances of this particular case, the Ombudsman's view was that the

Highways Department could have been more helpful in specifying what was required. The delay and lack of information amounted to maladministration. The Ombudsman upheld the complaint against the Council. He recommended that the Council apologise to Mrs H and pay her the equivalent of the 'Certificate of Lawfulness for a Proposed Use or Development' application fee that she had incurred.

Case reference 201001866 & 201000458

February 2011 – Handling of planning application – Bridgend County Borough Council

Miss D and Mr H complained that the Council had failed to notify them of a planning application to vary the design of a property on a neighbouring plot of land to their home. The application substituted a large decked area for what had originally been planned as a terraced garden. Miss D and Mr H also complained that the Council failed to properly consider the impact of this development on neighbouring properties.

The Council had already accepted that it failed to send a notification letter to Miss D and Mr H and had apologised for that. The Ombudsman considered that as other properties had been notified of the planning application in this way, Miss D and Mr H should also have been sent a letter. As a consequence they lost the opportunity to comment on the application.

The Ombudsman also criticised the consideration of the planning application. He accepted that the Council had been correct to consider the fact that the new structure would have caused less of a problem with overlooking than the garden that had originally been proposed; however, the Ombudsman found that the Council had failed to give due consideration to the impact of the scale and dominance of the structure and the fact that it did not comply with the Council's Development Plan.

The Ombudsman upheld the complaints. He recommended that the Council should apologise for the failings identified in the report; pay Miss D and Mr H £1,000 in recognition of the injustice they had been caused; and explore with Miss D and Mr H and the owner(s) of the adjoining property whether any mitigating works could be put in place. The Ombudsman was pleased to note that the Council had already altered the way it decides which properties will be notified of planning applications, and it is likely that this will reduce the risk of properties being overlooked in the notification process in future. The Council accepted the Ombudsman's recommendations.

Case reference 201000674

February 2011 – Handling of planning application – Rhondda Cynon Taf County Borough Council

Dr & Mrs G complained originally that they were not consulted in writing by the Council on a planning application to construct a kennel close to their new property. Site notices were placed in such a position, moreover, that members of the local community were unaware of the plans for the development and they would have raised concerns over the potential increased traffic, noise pollution and the precedent for development in a rural environment. The complainants say they will be significantly affected due to their position near to the proposed development and this has caused considerable stress and worry.

Following the submission of the complaint it became apparent that the planning decision had been made as a departure from the relevant development plan and contrary to strong officer recommendation to refuse the application. It was argued that the development was an unjustified sporadic development in the countryside and therefore contrary to policy. Guidance issued by the Welsh Assembly Government makes clear that when a decision is made which is a departure from adopted policy or against the written advice of a local planning authority's officers then the reasons should be good and recorded in the Committee's minute. They were not recorded in this instance. A significant error was also made by the inclusion in the planning report prepared for the Committee which made the decision of dimensions for the proposed building of a footprint which the Ombudsman's Professional Adviser noted was four times smaller in area than the drawings indicated. He believed that the incorrect dimensions may have been a factor in the members' minds when assessing the scheme and finding it acceptable.

Although the Ombudsman believes that the Council was not at fault in the way it carried out the consultation exercise he has found maladministration in the failure of the Council to record the reasons for the planning decision in the minute of the meeting and due to the error of the inclusion of the significantly incorrect size of the footprint of the proposed kennel. A recommendation has been made to the Council that an appropriate remedy for the injustice caused to the complainants would be payment of £1,500 to compensate them for the stress and worry caused by the planning approval and for the time and effort in complaining to the Council and the Ombudsman. The Ombudsman also recommends that the Council instructs the District Valuer to assess any diminution in the value of Dr & Mrs G's property as a result of the presence of the kennel when it is in operation and that an undertaking be given that the Council will investigate thoroughly any reports of a noise nuisance emanating from the kennel.

The Council has accepted the findings of the report and agreed to implement the recommendations.

Case reference 200901082

February 2011 – Handling of planning application – Powys County Council

Mr B complained that following his reports of unauthorised development in a field adjacent to his property, the Council delayed taking enforcement action for 18 months. During that time a pond, banking, steps and fencing were constructed and a caravan and leisure equipment have been used on a regular basis. Although the time for compliance with the enforcement notice, which stipulated the removal of the unauthorised works and the reinstatement of the land had passed, a retrospective planning application was submitted for the retention of the development. This application was approved by delegated decision following a report prepared by an officer from another planning authority. Mr B believed the decision should have been made by the Planning Committee which had authorised enforcement action. The planning application did not include the caravan but this is in continual use despite the Council stating that its use is only permitted for no more than 2 days in succession or 28 days in a period of 12 months for the purposes of habitation.

Mr B became very frustrated by the process and his concerns were exacerbated by the Council's failure to respond to his representations on the planning issues and investigate his formal complaints.

The Ombudsman found maladministration by the Council due to the lengthy delays in taking enforcement action and failing to respond to Mr B's representations and formal complaints. The Ombudsman recommended that the Council apologise and pay the complainant £500 in recognition of its failings. Whilst it would have been advisable to have placed the planning application before the Planning Committee for determination, given the fact that it had authorised enforcement action, the failure to do so was not maladministration because the Council's planning protocol was not breached. The Council has given an undertaking to monitor the siting and the use of the caravan. If it does not do so, it is open to Mr B to submit a fresh complaint.

Case reference 200900789

February 2011 – Unauthorised development – Cardiff County Council

Mr A complained that the Council's Planning Enforcement Section failed to enforce a sound insulation scheme condition. This condition was attached to the planning permission granted for Recording Studios ('the Studios'). These Studios were close to Mr A's property. Mr A said that the Council did not enforce a Breach of Condition Notice. He complained that it failed to prosecute the Studios for "playing amplified music". He reported that loud amplified music was often played in the Studios until midnight. He indicated that the "continual nuisance" caused by this music had adversely affected his health. He said that the Council should have enforced compliance with the sound insulation scheme condition.

The Ombudsman upheld Mr A's complaint. He was also critical of the Council's Pollution Control Section in terms of its role in the matters complained about. He recommended that the Council should apologise to Mr A for the failings identified. He asked it to pay him £250 because of the time and trouble that he had incurred whilst pursuing his complaint about the noise nuisance and the Council's response to it. He recommended that it should prepare a written procedure for discharging planning conditions. He asked it to develop a mechanism for ensuring that all relevant enforcement options are considered when a planning control breach is identified. He recommended that it should formulate a planning enforcement policy. He asked it to send Mr A a copy of the planning condition procedure and the enforcement policy prepared as a result of his investigation. The Council agreed to comply with all of the recommendations made.

Case reference 200900007

February 2011 – Handling of planning application – Powys County Council

A group of residents complained about the use of a nearby wood for clay target shooting. They said that the Council failed to comply with government guidance when granting a third temporary consent for the use. They were unhappy with the time taken to deal with a number of applications made to make the use permanent and said that the highway safety implications of the activity had not been properly assessed. Following refusal of consent they said that the Council failed to take effective enforcement action when shooting continued. When they complained to the Council, the response to their complaint was delayed.

The Ombudsman upheld the bulk of their complaint. He found that there were a number of failings by the Council including the grant of a third temporary consent (for 10 years) which was against government advice. Monitoring of the use had not been carried out during this period. The

Ombudsman was also critical of the time taken to deal with two of the planning applications made to make the use permanent. He said that the developer had been allowed to prevaricate and had benefitted from the lengthy decision making process in that the unauthorised use was continuing on the site. The delay also had an impact on the timescale for the appeal hearings which added to the uncertainty in this case. The Ombudsman concluded that the Council had failed to take effective enforcement action following the refusal of consent in November 2007. He said that an enforcement notice could have been served some two years earlier than it actually was and in the meantime the shoot was continuing without planning consent. In responding to the residents' formal complaint the Council failed to comply with the timescales in its own complaints procedure.

The Ombudsman recommended a payment to the members of the group living close to the site to reflect uncertainty over a long period. The Council was also required to provide information about any further monitoring of the site, which was granted consent at appeal and to reach a view about enforcement. It was also to review staffing levels for planning enforcement and to ensure that staff were appropriately trained.

Case reference 200801383

February 2011 – Handling of planning application – Powys County Council

Mr P complained about the use of a nearby wood for clay target shooting. He said that the Council had delayed in determining the most recent planning application to make the use permanent. Mr P was also unhappy about the way in which the Council, as highways authority had commented on this and earlier applications. He said that the Council had also failed to take enforcement action when the shooting had continued following the refusal of planning consent in November 2007.

The Ombudsman upheld most of the complaint. He found that the Council had delayed in determining the application and had allowed the developer to prevaricate. The delay also had an impact on the timescale for the appeal hearings which added to the uncertainty in this case. The Ombudsman also concluded that an enforcement notice could have been served some two years earlier than it actually was and in that time the shoot was operating without planning consent. The Ombudsman recommended that the Council should apologise to Mr P and make him a payment of £200. It was also required to review staffing levels for planning enforcement and to ensure that staff were appropriately trained.

Case reference 200802318

February 2011 – Handling of planning application – Cyngor Gwynedd

Mr D complained on behalf of his daughter, Mrs O, about flooding in her rear garden which he said began when developers constructed an access road for a new development to the rear of her property. In particular, Mr D said that the decision of the Council to grant planning permission for the development was reached without a full investigation of the suitability of the site and failing to adequately safeguard adjoining properties from flooding. He said that the letter of objection written by his daughter had been disregarded by the Council. Mr D also said that complaints made by Mrs O's neighbour were treated differently to her own and that the Council did not respond adequately to her complaint.

The investigation found that the Council had failed to specify appropriate measures to deal with drainage matters in granting consent for the development and that this amounted to maladministration. It however found that the Council took into account concerns regarding drainage issues on the application site in determining the planning application. The investigation also found that there was no evidence of any complaints made by Mrs O between 2003 and 2009 and that the Council did not act inappropriately in dealing with her neighbour's complaint or fail to respond to her complaints.

Following the issue of the draft report, the Council confirmed it would carry out the work it considered necessary to remedy the flooding issues at Mrs O's property in a 'one off' attempt to remedy the problem. It said that it would carry out the work on a 'without prejudice' basis and that it would not take on responsibility for future repair or maintenance of the works.

The offer was considered reasonable in the circumstances of the complaint and Mr D accepted the Council's proposal.

Case reference 200901375

January 2011 – Handling of planning application – Cyngor Sir Ceredigion

Mr Z complained about aspects of the Council's handling of a housing development with respect to planning issues. He said that the Council did not protect local residents from a known flood risk from a local river, which the development and increases in its size, had made worse. He specifically highlighted, among other matters, technical issues about drainage on site, related issues of compliance with planning conditions which the Council had imposed and complaint handling.

The Ombudsman upheld some aspects of Mr Z's complaint. He found that the Council had not responded quickly enough to the developer's failure to comply with conditions despite its own identification of the importance of those conditions. He also concluded that the Council had not responded well to Mr Z's complaints in a number of aspects. The Ombudsman made various recommendations including that the Council pay Mr Z £500 for additional distress over the flood risk and his time and trouble. The Council agreed to implement the Ombudsman's recommendations.

Case reference 201000086

Not Upheld

March 2011 – Unauthorised development – Rhondda Cynon Taf County Borough Council

Mr X complained about the way in which planning consent had been granted, some years previously, for phase 2 of a housing development. He also complained about the failure by the Council to take enforcement action when the developer failed to comply with conditions attached to the planning consent. These conditions related primarily to the highway conditions, the submission of a drainage scheme, and the location and level of a play area and adjoining footpath immediately behind Mr X's home.

The Ombudsman considered the complaint concerning the grant of planning consent to be out of time, and declined to investigate it. He found that although the conditions relating to highway improvements had not been complied with at the relevant time, the works had now been completed. The Council was pursuing the regularisation of the drainage condition, and it was likely that the drains would be adopted by Dwr Cymru/Welsh Water and, subsequently, the highways by the Council. The Council considered the location and level of the play area and the footpath to be acceptable, and decided that it was not expedient to pursue enforcement action. That was a decision the Council was entitled to take. The Ombudsman did not uphold the complaint.

Case reference 200901839

March 2011 – Unauthorised development – Rhondda Cynon Taf County Borough Council

Mr X complained about the way in which planning consent had been granted, some years previously, for the second phase of a housing development. He also complained about the failure by the Council to take enforcement action when the developer failed to comply with conditions attached to the planning consent. These conditions related primarily to the highway conditions, the submission of a drainage scheme, and the location and level of a play area and adjoining footpath immediately behind Mr X's home.

The Ombudsman considered the complaint concerning the grant of planning consent to be out of time, and declined to investigate it. He found that although the conditions relating to highway improvements had not been complied with at the relevant time, the works had now been completed. The Council was pursuing the regularisation of the drainage condition, and it was likely that the drains would be adopted by Dwr Cymru/Welsh Water and subsequently the highways by the Council. The Council considered the location and level of the play area and the footpath to be acceptable, and decided that it was not expedient to pursue enforcement action. That was a decision the Council was entitled to take. The Ombudsman did not uphold the complaint.

Case reference 200801839

March 2011 – Unauthorised development – Cyngor Sir Ceredigion

Mr X complained about the failure of Cyngor Sir Ceredigion ("the Council") to take robust enforcement action against a coffee outlet ("Z") that was operating in the centre of town Y. Mr X complained that Z did not have planning permission when it opened and subsequently had a planning application refused, but continued to operate illegally. Mr X said that his business, which was situated on the same street as Z, had since closed at a personal loss of some £150,000. Mr X attributed the closure of his business and his financial loss to the Council's failure to take sufficiently robust action against Z.

The investigation found that the Council had taken some enforcement action against Z but, due to the economic downturn's effect on Y, it had decided that serving an Enforcement Notice on Z would not be expedient at that time. The investigation found that there was no evidence that the Council had unreasonably failed to take enforcement action against Z or of maladministration on its part in dealing with the matter. In the absence of such evidence, the complaint was not upheld.

Case reference 200901669

February 2011 – Handling of planning application – Brecon Beacons National Park Authority

Mr S complained that the Authority was responsible for delays and the misinterpretation of planning regulations in respect of developments at a neighbouring property covered by three planning permissions in 2003, 2004 and 2005. He said that, as a result of the alleged failures by the Authority, he had been unable to use an area for grazing. He also said that the matter started in 2005 but he had not complained to the Ombudsman before now as he was led to believe that the matter was being considered by the Authority. In support of his complaint Mr S also provided details about a private dispute between him and his neighbour about a right of way across Mr S's property along with allegations of Anti Social Behaviour, property damage and trespass.

Mr S complained to the Authority about alleged breaches of the planning regulations in mid 2006; the Authority registered his complaint as a Planning Enforcement case. In October 2006 the Authority informed him that no enforcement action would be taken as the development was permitted under Permitted Development Rights. There is no evidence to suggest there was any maladministration in reaching the decision or that the decision taken was perverse. Enforcement action is discretionary; government guidance encourages councils to try informal methods of dealing with planning problems. Formal enforcement would normally be a last resort. Mr S continued to dispute the decision and in June 2007 Mr S was advised by the Authority that the decision was final and there was no right of appeal.

Mr S continued to correspond with the Authority about the alleged planning breaches and in March 2008 the Authority registered a new Planning Enforcement case. In March 2010 the authority again reached the decision that no enforcement action was needed. Whilst it took two years to get to that stage; the time taken was as a consequence of the resources available to the Authority and Mr S was kept updated throughout.

Mr S was informed that the Ombudsman cannot intervene in private disputes between individuals. He was advised to report matters such as Anti Social Behaviour, property damage and trespass to the Police. He was also advised that the dispute between him and his neighbour about the established right of way is a private dispute. As he had previously been involved in legal proceeding about the matter, the proper place for him to pursue this further is clearly therefore the Courts. It is not a matter for the Ombudsman nor is it a matter for the Authority.

As much of Mr S's complaint was outside the Ombudsman's jurisdiction, apart from directing Mr S to the appropriate authorities, he did not comment on those issues. The Ombudsman's investigation found no evidence of maladministration on the part of the Brecon Beacons National Park Authority; he did not uphold the complaint.

Case reference 201000233

February 2011 – Handling of planning application – Bridgend County Borough Council

Mr A complained about the Council's management of two applications - a Planning application and a Conservation Area Consent application. Mr A was concerned that the Council was unwilling to recognise the size of the proposed development and the amount of disruption which would arise during its construction. Mr A also complained that the Council in considering these applications had ignored his references to a similar development which had raised concerns for him. Mr A also considered the Council's insistence that the disruption would only be short-term to be dishonest.

Mr A was concerned that the development would not enhance the conservation area in which it was located and that the Council did not take his objections (on grounds of privacy, outlook and overshadowing) seriously.

Mr A also complained that due to the number of objections made to the applications that these should not have been dealt with under delegated authority arrangements and instead should have been considered by the Council's Development Control Committee. Mr A was also dissatisfied with the Council's response to his related complaint.

The Ombudsman found that the Council had dealt with both applications in a reasonable manner and that representations made about the two applications were properly considered. He did not uphold Mr A's complaint but did invite the Council to consider some improvements to its practice.

Case reference 200901696

February 2011 – Handling of planning application – Environment Agency

Mr M complained that Environment Agency Wales ("EAW"), a statutory consultee, had delayed in providing Powys County Council ("the Council") with the relevant information it needed to determine his neighbour's retrospective planning application for a drainage channel. This element of the complaint was not upheld. Whilst EAW had failed in its duty to provide the Council with a substantive response to its request for observations within the specified 21 days, this delay did not alter the outcome because EAW did not wish to make any observations on the matter, therefore there was no injustice to Mr M. With respect to the subsequent points of clarification requested from EAW by the Council, there was an occasion where it took EAW five months to provide a response. Although EAW did apologise for the delay and provided a reasonable explanation to the Council, such a delay without updating the Council on its progress is poor practice. EAW has stated that it is running a pilot scheme designed to enable it to focus its resources where they are needed most and improve the quality and timeliness of the planning responses for customers.

Mr M also complained that the Council had failed to enforce planning conditions on the neighbouring property and as a result water was being diverted to his property. The planning conditions in question related to a scheme which required the monitoring of three identified watercourses in the area as well as any watercourses that were to be lost as a result of the work being carried out at the neighbouring site. This element of the complaint was not upheld. The tributary on Mr M's land was not one of those identified by the scheme, nor was it to be lost as a result of the work carried out. The water being diverted to Mr M's property had started to flow

prior to the neighbouring property seeking a variation to its consent to discharge and planning consent. Therefore, it was impossible for the Council to carry out the required measurements and surveys and take adequate enforcement action.

Case reference 200901633

February 2011 – Handling of planning application – Powys County Council

Mr S complained that Powys County Council's ("the Council") Planning Department had failed to take into consideration the objections that he had raised in respect of a planning application granted on 14 July 2009. He also complained that the Council's failure to adequately communicate with him was evidence of its failure to conform to established rules and procedures. Finally, Mr S said that the Planning Department had shown bias to the applicant throughout the process and that there was no evidence in the planning file to show that his objections had been considered or addressed by any of the relevant departments and agencies.

The Ombudsman's investigation concluded that it was for the Council's Planning Department to decide what weight to place upon evidence to determine the application before it. It was not for the Ombudsman to question the merits of a decision reached in the absence of maladministration unless the decision was perverse or unreasonable. He concluded that the fact that the outcome of those deliberations was not acceptable to everyone was not an indicator of maladministration. The Ombudsman was satisfied that the planning officer had dealt with the application on its merits and, on the evidence before him, reached a reasoned conclusion on which to grant consent. Mr S's complaint was therefore not upheld.

Case reference 200901543

February 2011 – Handling of planning application – Isle of Anglesey County Council

Mr A complained about the Council's management of a planning application. The application concerned an increase in the importation of waste materials to a quarry. Mr A argued that the Council did not take the decision to approve this application properly for a number of reasons. These included the Council's alleged failure to consider the objections made by local residents, a significant surface water issue and the completion of an Environmental Impact Assessment. He also suggested that the Council should have conducted a traffic impact survey. He noted that the applicant was an appointed Council contractor and implied that the Council did not manage this application impartially because of this.

The Ombudsman found that the Council had considered the objections received and that the assessment completed by its Highways Service was reasonable. He concluded that it was unnecessary for the Council to have completed a traffic impact survey or an Environmental Impact Assessment. He also considered that the Council's management of the surface water issue was adequate. He found no evidence that the Council had acted improperly and did not uphold Mr A's complaint.

Case reference 200901257

February 2011 – Unauthorised development – Cyngor Gwynedd

Mrs X complained about the Council's inaction in relation to a taxi business being run from a neighbouring property. She complained about the number of vehicles operating from the property and the detrimental impact that they had, particularly late at night and at busy periods. Mainly, she complained that the business' activities broke planning rules. Also, she complained about the failure of the Licensing Unit to restrict the number of taxi licences being granted to the business. Additionally, she complained about the nuisance that the vehicles caused.

The Ombudsman did not uphold the complaint. The Ombudsman found that there was no evidence of maladministration on the part of the Council in this matter. However, he criticised the Council for its poor standard of communication with Mrs X and her husband in relation to the planning situation and the likelihood of it taking planning enforcement action against the owner of the business.

Case reference 200900581

January 2011 – Unauthorised development – Powys County Council

Mr Y complained about the unsightly condition of his neighbours' property and about the inaction and unreasonable delay on the part of the Council in dealing with the matter. Mr Y had originally complained about this issue to the Council in 2003.

The Ombudsman found no evidence that the Council had failed to act in accordance with policy, procedure, guidance or the law in this matter. Additionally, the Ombudsman could not conclude that the Council had acted unreasonably in this matter. There was no evidence of unreasonable delay or inaction on the part of the Council in pursuing planning enforcement action against Mr Y's neighbours. The Ombudsman did not uphold the complaint.

Case reference 200900233

Housing Summaries

Upheld

March 2011 – Repairs and maintenance – Powys County Council

Mrs A complained that the Council had refused to undertake the necessary adaptations to her kitchen and bathroom that would allow her to continue living independently as a disabled person.

The Ombudsman partly upheld Mrs A's complaints. In view of the fact that the Council had already made appropriate arrangements for major adaptations to Mrs A's bathroom, he found that it had been unnecessarily difficult for her to obtain an assessment of her need for adaptations to her kitchen. There were also examples of poor record keeping to the extent that it was not always possible to establish the full facts of the case. Finally, the Ombudsman was critical that the Council had failed to invoke its formal complaints procedure when Mrs A had approached the Council to complain on three separate occasions.

He recommended that the Council should apologise to Mrs A for the failings identified and that it pay her £250. The Council also agreed to commission a further independent assessment of Mrs A's need for adaptations to her kitchen and to identify and undertake improvement measures to address the shortcoming identified by the investigation.

Case reference 200901325

March 2011- Applications, allocations, transfer and exchanges – Wrexham County Borough Council

Mr S's main complaint centred on how the Council's delay in dealing with his housing situation had adversely impacted on him. Mr S, a double amputee and wheelchair user, submitted a housing application in 2007. Amongst the documentation he submitted was supporting information from the Council's occupational therapist. As part of his application, Mr S highlighted that his family home was unsuitable as it was not wheelchair accessible. Consequently, he had to crawl on his hands and knees to get around the property: he faced similar difficulties accessing the only bathroom which was located on the first floor. As part of his complaint, Mr S also expressed dissatisfaction with the way the Council had dealt with both his social services and housing complaints under its formal complaints procedure.

The Ombudsman found a failure by the Council to consider whether its homelessness duties were triggered. Had the Council initiated homelessness inquiries, the Ombudsman was of the view that by the time Mr S submitted his housing application in June 2007, there was sufficient evidence for a reasonable council to have concluded that it owed Mr S the full housing duty under the homelessness legislation. The Ombudsman also identified (in conjunction with other investigations carried out under the Council's formal complaints procedure), inadequacies in the Council's record keeping which the Ombudsman concluded appeared to amount to systemic failings. This was coupled with poor communication and a lack of transparency in the way the Council's Medical Panel operated and made decisions on the award of medical points. Finally, the Ombudsman found shortcomings in the Council's complaints handling which included unacceptable delays in dealing with Mr S's complaints. The Ombudsman therefore substantially upheld Mr S's complaints and made findings of maladministration.

The Council accepted the Ombudsman recommendations. He recommended that, within one month of the report being finalised, the Council's Chief Executive should apologise to Mr S for the identified failings. In addition, he said that the Council should pay Mr S redress of £1500 to reflect the fact that he was in unsuitable accommodation for longer than he should have been due to the Council's failure to act in accordance with its statutory duties. He also recommended a further payment of £250 to Mr S because of the Council's shortcomings in its complaints handling. Finally, the Council was asked to produce an action plan setting out how it intended to address the shortcomings identified in the report.

Case reference 200901664

March 2011 – Applications, allocations, transfer and exchanges – Wrexham County Borough Council

Ms A complained about the Council's response to her housing repair requests, its management of her tenancy and her housing application. She indicated that it did not complete any of the repairs recommended by one of its inspectors for some time. She implied that it never completed all of them. She complained that the Council treated her unfairly when addressing tenancy issues. She suggested that it did not process her housing application properly. She indicated that she was dissatisfied with its response to her complaints about these matters.

The Ombudsman fully upheld the repair and application elements of Ms A's complaint. He recommended that the Council should amend its Housing Allocation Policy to include a room space qualification. He asked it to ensure that it keeps written records which explain why health and social care points have, or have not, been awarded to a housing application. He recommended that it should ensure that it complies with Part 7 of the Housing Act 1996 (as amended) and related guidance when considering housing applications. He partly upheld that aspect of Ms A's complaint which concerned the Council's complaint handling. He asked the Council to amend its complaints procedure to reflect the fact that it might not provide a full written response to a complaint if it has been possible to resolve it reasonably quickly by other means. He recommended that the Council should apologise to Ms A for the failings identified. He asked it to pay her £250 in recognition of these failings and the time and trouble she had incurred whilst pursuing her complaint. The Council agreed to comply with all of these recommendations. The Ombudsman did not uphold that aspect of Ms A's complaint which concerned the Council's management of her tenancy.

Case reference 200901159

March 2011 – Homeless person issues – Cardiff County Council

Ms A's complaint centred on the way that the Council dealt with her daughter Miss S during the period that she and the family were homeless. Miss S who had mental health problems had been diagnosed with schizophrenia. Ms A expressed concern that the Council had failed to consider or obtain evidence from her daughter's mental health Social Worker and Community Psychiatric Nurse about the effect that being homeless was having on Miss S.

Ms A had been evicted from the Council's temporary accommodation in June 2007 for rent arrears. The Council subsequently concluded that Ms A had made herself intentionally homeless from her temporary accommodation. The family including Miss S were homeless until 24 August 2007 when Ms A managed to secure private rented accommodation.

The report noted that the Council had introduced improved procedural guidance and staff training in response to previous Ombudsman's reports covering the same period. These reports had dealt with the triggering of the Council's homelessness duties. However, the Ombudsman was critical of the Council's Housing Advice Unit's ("the HAU") failure to act corporately. He was also concerned that once it had been determined at Miss S's homelessness interview in July 2007 that she lacked capacity to make a homelessness application that the HAU had failed to make an immediate referral to Social Services under section 21 of the National Assistance Act 1948 ("NAA 1948") which serves to trigger Social Services' duty to provide accommodation to certain vulnerable groups.

The Ombudsman was critical of the process by which the Council had concluded that Miss S lacked capacity. He also raised concerns that the Council's approach had left it open to the inference that its decision making process had been tainted by a wish to avoid accommodating Ms A. The Ombudsman also found failings in how the Council's Social Services had dealt with Miss S's case and was critical that it had not itself considered its section 21 NAA 1948 duties; particularly given that Miss S had been assigned a Social Worker since early 2007.

As well as a failure to adhere to its statutory duties, other failings identified in the report included: poor communication; a blinkered approach to considering Miss S's case; and a lack of urgency or concern about Miss S's housing predicament.

Amongst the Ombudsman's recommendations were that within one month of the report being finalised the Council's Chief Executive should apologise to Ms A for the failings identified in the report. The Ombudsman also highlighted that had it not been for Miss S's sudden death, he would have recommended a payment of £750 as appropriate redress for the injustice that the Council's failings had caused Miss S. However, in the circumstances he expressed the hope that the Council would, in recognition of its shortcomings, consider making a £750 payment to an appropriate mental health charity operating within its area. He also requested that the Council should provide documentary evidence that it had either addressed the failings set out in the report or it should produce an action plan setting out how it intended to address those shortcomings within three months.

Case reference 200900981

February 2011 – Neighbour disputes and anti-social behaviour – The Vale of Glamorgan Council

Mrs K, who is an owner occupier, complained that the Council failed to investigate her complaints about the anti social behaviour of a neighbour and the visitors to her property. Mrs K submitted several complaints to the Council over a period of six years from 2002 to 2009. She also complained that the Council had failed to take any action to prevent the behaviour complained of, to address her concerns.

The Ombudsman found that prior to the introduction of its Anti-Social Behaviour (ASB) Policy in 2005, the Council dealt with the complaints received in an appropriate manner by issuing notices to Mrs K's neighbour in respect of her behaviour, although it initially delayed in doing so. However, when further complaints were received the Council failed to investigate them promptly and as a consequence no action could be taken to enforce the terms of one of the notices.

The Council failed to fully investigate the majority of Mrs K's subsequent complaints and to consider the options open to it, other than repossession of the tenancy, as mentioned in its published ASB policy at the relevant time. There was also an absence of consistent reasoned recordings to explain Housing Officers' assessments and subsequent decisions not to take action. Finally, there was a distinct lack of communication with Mrs K by way of update or explanation for action or inaction by the Officers.

The Council had already agreed to review its ASB policy and procedures following an earlier unrelated complaint. The Council agreed to apologise to Mrs K, to pay her £1250 and to make sure that any future complaints were investigated properly. It agreed to pay £750 to her son in respect of the injustice suffered by him. It agreed to introduce more detailed procedures and to review the training needs of its staff.

Case reference 200901391

February 2011 – Group or block repair/improvement grants – Cyngor Sir Ceredigion

Mrs R applied for a Renovation Assistance Grant for a property she owned and in which her son resided. She appointed the Council's Housing Grants Agency to act as her Agent ("the Agent"). Mrs R complained that the Agent failed to monitor the grant work carried out by the Contractor in accordance with its Grant Agent's Brief. She also complained about the standard of work carried out at the property and the delays in completing the work.

The Ombudsman's investigation found that the Council had a duty to properly monitor the grant work to ensure that it was carried out to an acceptable standard but did not do so adequately. The Ombudsman also identified issues with poor and inadequate record keeping. Mrs R's complaint was upheld. The Ombudsman recommended that the Council's Chief Executive should apologise to Mrs R for the shortcomings identified and pay her the sum of £1,000 to reflect this and the inconvenience caused to her in pursuing her complaint to the Ombudsman. The Ombudsman also made recommendations in terms of monitoring grant work and training of staff.

Case reference 200900456

January 2011 – Applications, allocations, transfers and exchanges – Blaenau Gwent County Borough Council

Ms M (a tenant of the Council) and her partner, Mr N, complained that the Council: failed to properly deal with a transfer application to larger family home (as they claimed that they were statutorily overcrowded); failed to consider the reasonableness of their continuing to live there (and so assess if they were homeless); and failed to reply to letters from their solicitor in a timely way. Since the investigation began the Council had transferred its housing stock but retained a number of relevant housing functions.

The investigation found a number of basic failings by the Council, representing serious maladministration: including that for a 3 year period (until May 2006) the Council had failed to amend its housing allocation policy in accordance with legal changes (although this would have affected all waiting list applicants not just Ms M); it wrongly only applied one of the available tests for assessing space overcrowding; it never visited applicants who said they were overcrowded; it conducted no assessment under the Health and Safety Rating System; and it failed to recognise when its duty to carry out homelessness enquires might be engaged. In addition, there were other recording failures relating to Ms M's transfer application, including a failure to reply to her solicitor. In largely upholding the complaint, the Ombudsman made a number of recommendations including an apology and £500 to Ms M & Mr N for the failings identified, and an apology to the solicitor. He also recommended that: the Council should undertake an assessment of whether the family's circumstances meant they may be homeless; and its staff still involved in assessment of housing applications should undergo training on the law regarding overcrowding, the HSRS, and the recognition of homelessness duties.

The Council agreed to implement all the recommendations.

Case reference 200900971

January 2011 – Neighbour disputes and anti-social behaviour – The Vale of Glamorgan Council

The Firs is a sheltered housing complex owned by the Vale of Glamorgan Council. The home is linked to 24 hour community alarm system and a warden provides help and assistance to all residents. Sheltered housing schemes with a warden accommodate persons over retirement age.

Mrs B has lived at the Firs since 14 January 2002. Her neighbour Mr F was offered and accepted a one bedroom flat on 18 August 2008.

By February 2009 the Council had received numerous complaints from residents of the Firs, including Mrs B, regarding Mr F/Miss H's behaviour and the smells from his flat, together with complaints of smoke from Mr F's property leading to the activation of the fire alarm at the building, often in the early hours of the morning, and problems with the security doors being left ajar by him or Miss H.

Despite repeated and frequent complaints from Mrs B and other residents of the Firs the Council failed to take any positive steps to resolve the conduct of anti social behaviour by either Mr F or Miss H, whilst it informed Mrs B and the residents at the Firs that its Social Services department are working with both Mr F and Miss H to resolve the issues. The Council have also failed to adequately communicate with Mrs B.

The Ombudsman found that the Council's published procedures were not sufficiently detailed and that overall the Council's dealings with Mrs B were not helped by the lack of a detailed "step by step" procedure. In particular the Council had failed to treat Mrs B's complaints as complaints of anti social behaviour and so did not consider them under the terms of its policy. There was a failure

to act promptly and to consider the options open to the Council, as set out in its published ASB policy. There was also an absence of consistent reasoned recordings to evidence Officers' multi agency dealings.

The Council agreed to apologise to Mrs B to pay her £500 and to make sure that any fresh complaints were investigated properly. It also undertook to introduce more detailed procedures and to review the training needs of its staff.

Case reference 200900731

January 2011 – Neighbour disputes and anti-social behaviour – Cardiff County Council

Mr B complained that since 2006 Cardiff County Council ("the Council") had failed to adequately deal with the numerous complaints that had been made about his neighbour, Mr X's, anti social behaviour / noise nuisance. Mr B also complained that the Council had failed to keep him informed of the progress of its investigation into the complaints.

It was clear that whilst the Council's Housing and Noise and Air Pollution Departments had worked together, which had produced a positive result in 2009/10, the Council's Housing Department's actions, particularly its failure to take action against Mr X in 2007 had resulted in Mr B and Mrs A feeling let down by the Council. In view of the Council's failure to either take further action at that time, or document the reason for not taking action, this element of Mr B's complaint was upheld. However it was recognised that in his response to Mr B's complaint about this matter to the Council, the District Manager for Housing Management had accepted that the failing had occurred and apologised.

Mr B also complained that the Council had failed to keep him adequately informed of the progress of its investigation into his complaint. In his response to Mr B's complaint about this matter, the District Manager for Housing Management said that Housing Team Manager 1 had recognised that she had not kept Mr B up to date on the investigation into his complaint and had apologised during her telephone conversation with Mr B on 8 July 2009. This element of Mr B's complaint was upheld. However it was recognised that in his response to Mr B, The District Manager for Housing Management also accepted that this failing had occurred and apologised.

The following recommendations were made and accepted by the Council:

- the Council apologise to Mr B for the maladministration and poor practice identified in the report;
- the Council pay Mr B the sum of £500 in recognition of the maladministration and poor practice identified in the report;
- the Council remind its Housing staff about the importance of providing regular updates to complainants and documenting decisions taken that are contrary to the Nuisance Policy and Procedure;

- the Council take account of the poor practice found in this matter and take steps to ensure that in future "Emergency Repairs" requests can be made by affected members of the public.

Case reference 200900727

January 2011 – Repairs and maintenance – Cardiff County Council

Mrs B complained that during the installation of new windows at her property, the Council's contractor damaged her bedroom radiator causing a leak that left water damage on her living room ceiling and wall, and that the Council failed to carry out the repairs in a timely manner.

The Council was made aware of the damage to Mrs B's property on 10 September 2007 when she submitted a Liability Claim Form detailing the damage that had occurred. When completing the form Mrs B said that the damage had occurred as a result of the actions of the Council's contractor, therefore the Council forwarded her insurance claim on to the contractor, however the contractor denied liability.

The Council's action in forwarding the Liability Claim Forms to its contractor, as the party responsible for the damage to the radiator, was reasonable. However the Council had been aware that the leak had caused damage to the property and had failed to take any action to repair that damage. In fact the Council took no further action on this matter until almost one year later, following a letter from Mrs B's MP, who pointed out that damage had occurred and the property was still in need of repair. Mrs B was asked to submit another insurance claim, which again was forwarded to the contractor who denied liability. Neither Mrs B nor the Council chased the insurance claim and neither party were aware that the contractor had continued to deny liability. The damage to the property was left untouched.

The Council acknowledged that there was a delay in responding to Mrs B's insurance claim and complaint. Additionally whilst, given the content of Mrs B's Liability Claim Forms, it was reasonable for the Council to have forwarded the insurance claim to the contractor, the Council was aware that there was damage to the property and should have taken some action to repair that damage, particularly the structural damage.

It was recommended that the Council pay Mrs B £50 in recognition of the delay she had experienced and the time and trouble taken in pursuing her complaint. The Council has completed the repairs on Mrs B's property and has agreed to the recommendation that had been made.

Case reference 200902475

Not Upheld

March 2011 – Neighbour disputes and anti-social behaviour – Hafod Housing Association Ltd

Mrs H complained about the way in which the Housing Association dealt with her complaints about the antisocial behaviour of neighbouring children. She said that the responses were ineffective and slow and that there was a backlog of complaints which had not been addressed. She was also unhappy that issues which she raised as formal complaints had not been dealt with under the Housing Association's internal complaints procedure.

The Ombudsman did not uphold the bulk of the complaint on the basis that the Housing Association's response was reasonable, and that individual incidents had been collated and taken into account by officers. Given the age of the children, the Housing Association's responses were appropriate and parents had been reminded of their tenancy obligations when applicable. Also, the decision to deal with the behaviour of the one child by introducing a programme instead of a more formal contract, which was taken in partnership with other agencies, was not unreasonable. There had been a slight delay when the Housing Association could have been more proactive, when there were difficulties in engaging one of the partners, but this delay had not affected the overall outcome. The Ombudsman upheld Mrs H's complaint in relation to complaint handling.

Case reference 200901183

March 2011 – Estate management – Caerphilly County Borough Council

Mr K complained to the Ombudsman that the Council had been unfair to him in refusing consent to install a CCTV camera in an attempt to stop criminal damage being caused to his car; to erect a fence to prevent people passing his living room and bedroom windows to protect his privacy; to make improvements to communal areas and to lock the gate leading to one of those areas also used to dry clothes, which stopped anti-social behaviour when it was allowed originally. The complainant said that the Council also changed its mind after housing officers and the Leader of the Council stated that if Mr K purchased his flat under the Right to Buy provisions, then the situation with regard to the CCTV camera would be resolved. When he did buy the property, consent was still withheld. He said he would not have bought it if he had known this. He said that the Council was biased in favour of the lady in the flat above him, who had made a number of complaints about matters such as the camera. Her son worked for the Council and made comments about Mr & Mrs K's former tenancy status which could only have been obtained from a study of the housing records. The Council said it investigated that complaint but had taken no action.

The Council said that to enable the authority to grant landlord's consent to erect a camera, it must only be used to monitor activities within the boundaries of an applicant's property. It must not affect the privacy of any other person or property. As Mr K could not comply with this condition, consent was not granted. The policy was adopted after careful consideration and consultation within the Council, and whilst it is recognised that there is no breach of the data protection legislation for private use, the Council is itself bound by the legislation and could be liable if the decision was challenged. The Council said that when the Housing Officer visited Mr K and said that the issue could be resolved by purchasing the property, the application had already been made and the solicitor acting for Mr K made enquiries on that issue and improvements to the communal areas. The Council answered those enquiries. The Council said that with regard to applications to make improvements, whilst it had approved applications to carry out alterations within the property and to enclose the porch area outside the flat, Mr K had been refused permission to undertake works within the communal areas surrounding his property as these areas were not for his exclusive use, being shared with other residents in the block. The areas did not form part of the tenancy nor do they form part of the lease since the flat was purchased.

The Ombudsman found that the Council acted within its rights by withholding consent for the camera, improvements and the enclosure of communal areas. He was concerned, however, that the Council should be consistent in its decision making and recommended that they look into a reported enclosure of a communal area. The Council was also asked to inspect pathways and drains in the area as defects have been reported by Mr K. The Council agreed to these recommendations. Mr K was advised that the Ombudsman cannot consider the results of the Council's investigation into the alleged breach of confidentiality because he is expressly prevented from considering disciplinary matters by the provisions of the Public Services Ombudsman (Wales) Act 2005.

Case reference 200901521

February 2011 – Applications, allocations, transfer and exchanges – Wales and West Housing Association Ltd.

Mrs A reported that her husband had a fractured spine. She said that her son was visually impaired. She indicated that the Association had prioritised her housing transfer application because of their health needs. She implied that the Association was taking too long to find alternative accommodation for them given the priority status of her housing application. She reported that one of her neighbours had been subjecting her family to racial abuse for several months. She implied that the Association had no concern for the safety of her family. She complained that the Association had done nothing to help her. The Ombudsman did not uphold Mrs A's complaint.

Case reference 200900268

Education Summaries

Upheld

February 2011 – Special Educational Needs – Flintshire County Council

Ms S complained that the Council delayed in dealing with her request for an assessment of her son's Special Educational Needs. (The Council is required to determine such requests within six weeks of the date the request is received.) She said that the delay was critical and meant that the overall statementing process for her child was delayed and prejudiced the chances of him moving to a new school in time for the start of the new school year. Also the Council did not publicise its arrangements for a dispute resolution service for parents.

Ms S's complaint was upheld. The Ombudsman found that there was an identifiable four month delay before Ms S's request was put to its Moderation Panel when it agreed to an assessment of her child's needs. The Council had therefore failed to comply with the Code. It had also delayed in making known to her arrangements to resolve her dispute with the school. The Ombudsman recommended that the Council should apologise to Ms S and make a payment of £1,000 to include an amount for the time and trouble in making the complaint. The Ombudsman recommended that the Council should review its procedures for dealing with parental requests for assessment including the use of its standard letters and remind its staff of the timescales in the Code. He also asked the Council to ensure that details of its dispute resolution service are clearly publicised to parents.

Case reference 200902094

Adult Social Services Summaries

Upheld

March 2011 – Services for older people – Wrexham County Borough Council and former North Wales NHS Trust (now Betsi Cadwaladr University Health Board)

Ms F complained that the Council and the Trust delayed the discharge of her late father, Mr D, from hospital unnecessarily. She suggested that both the Council and the Trust failed to recognise her mother, Mrs D, as a carer. She said that the Council did not inform Mrs D of her right to a carer's assessment. She suggested that Council and Trust staff members could not give her any information about carers' assessments and direct payments. She indicated that the Council did not tell Mrs D that Mr D might have been eligible to receive continuing NHS health care. She suggested that Mr D was entitled to receive such care following his discharge from hospital. She indicated that she was dissatisfied with the way in which the Council and the Trust responded to her complaints about these issues.

The Ombudsman fully upheld the discharge and complaint handling elements of Ms F's complaint. He partly upheld that part of it which concerned the carer-related issues raised by Ms F. He recommended that the Council and the Board should produce a joint action plan to address the failings identified. He asked them to apologise to Ms F and Mrs D for these failings. He recommended that they should pay Ms F £250 in recognition of the time and trouble associated with pursuing her complaints. He also asked them to pay Mrs D £750 because of the failings related to Mr D's discharge and the additional distress caused as a result. The Council and the Board agreed to comply with all of the recommendations made. The Ombudsman did not uphold that aspect of Ms F's complaint which concerned continuing NHS health care.

Case reference 200901300 & 201000316

March 2011 – Services for older people – Wrexham County Borough Council

Mrs M complained on behalf of her mother about the Council's failure to properly consult on the introduction and implementation of a new charging system for the care provided by the Council to her mother, who resided in a sheltered housing unit.

The investigation found that the Council had properly followed the relevant statutory provisions and guidance issued for increasing charges for care received by service users who live in such accommodation. Furthermore the proposed charging structure was within the statutory framework and guidance and was relayed to the complainant with more than 12 weeks' notice of the implementation of the charge.

The complaint was however partially upheld as it was considered that the Council had failed to properly engage with the complainant's mother and to clearly explain at an early stage of the consultation process that its new Policy for care charges, at non residential accommodation, was to be based on a two tier charging system. The Council has agreed to apologise for this shortcoming and to make a time and trouble payment.

Case reference 200901139

January 2011 – Services for older people – Flintshire County Council, CSSIW and Independent Review Secretariat

Ms X complained about the bodies above. This followed an accident that her now late mother had whilst on an organised trip which had been arranged by the Care Home in which she resided. Ms X said that the Care Home had not properly investigated the accident or offered any apology. She added that the Council had placed her mother in the care Home and CSSIW was the relevant regulatory body, yet neither did enough to ensure that a proper investigation occurred. Ms X explained that she took the Council complaint to an Independent Review but she was dissatisfied with its role.

The Ombudsman found low level maladministration and upheld the complaints against the Council and CSSIW. He found that both bodies had failed to properly scrutinise the role of the Care Home in Ms X's mother's accident. He did not uphold the IRS complaint whilst having misgivings about its decisions. The Ombudsman recommended that the Council and CSSIW apologise to Ms X and pay her £75 each. He recommended that CSSIW remind its staff to look closely at attempts at local resolution by the bodies under its jurisdiction. The Council and CSSIW agreed to implement the recommendations.

Case reference 201000274 & 201000840

January 2011 – Services for vulnerable adults – Pembrokeshire County Council

Mrs J is the owner of a residential care home in the Council's area. Following allegations of verbal abuse from a member of staff at the care home to a service user, a Protection of Vulnerable Adults ('POVA') investigation was carried out by the Council. Mrs J complained about the investigation; in particular she complained about the threats she alleged the Council's Adult Protection Co-ordinator made to remove her status as a 'fit person' to run a care facility, the ability of the officer conducting the POVA investigation and the timing of her request for a letter concerning the demand she said had been made by the Adult Protection Co-ordinator for the dismissal of her employee. She also complained about the failure of the stage 2 complaints investigator to carry out an interview with her partner and the Council's decision not to follow all of the stage 3 complaint panel's recommendations.

The investigation found that there was no direct evidence of a threat being made to remove Mrs J's 'fit person' status. However, the investigation found that there was either an implicit threat to remove Mrs J's 'fit person' status or she felt that such a threat was implied following what was said by the Council's Adult Protection Co-ordinator and the complaint was partially upheld. The investigation also found that whilst the ability of the officer conducting the POVA investigation was not in doubt, he would have benefitted from more training as he did not have prior experience of conducting non-criminal investigations. This complaint was also partially upheld. The investigation found that Mrs J's request for a letter from the Council concerning the demand she said had been made for the dismissal of her employee was not made before 17 April 2008.

Mrs J's complaints about the failure of the stage 2 complaints investigator to carry out an interview with her partner and the Council's decision not to follow all of the stage 3 complaint panel's recommendations were not upheld by the investigation.

The Council agreed to the recommendations made by the investigation to apologise to Mrs J in respect of the two partially upheld complaints.

Case reference 200901732

Not Upheld

January 2011 – Services for older people – Independent Review Secretariat

See case reference 201000274 & 201000840 above.

Case reference 201000739

Roads and Transport Summaries

Not Upheld

January 2011 – Traffic regulation and management – Rhondda Cynon Taf County Borough Council

Mr X complained that the Council failed to consult local residents on a proposal for a traffic order before introducing a scheme of speed cushions outside his home.

The investigation found that the Council had met the statutory minimum requirements for publicity of the proposed traffic order. In its response to Mr X's complaint, the Council acknowledged that it was also its normal practice to notify local residents and it had failed to do so on this occasion. The Council had already apologised to Mr X for this failing and agreed to carry out consultation with local residents on modifications to the scheme. The Ombudsman considered that the Council had taken adequate steps to listen and learn from the complaint and that it had provided Mr X with an appropriate remedy.

Case reference 200801887

Children's Social Services Summaries

Upheld

March 2011 – Children in care – The Vale of Glamorgan Council

Ms M complained that The Vale of Glamorgan Council Children's Services Department failed to take appropriate action in response to her concerns that her children were at risk from their carers', with whom they live under the terms of a Residence Order. Ms M complained that the Council did not adhere to the correct child-protection protocol in assessing her claim that one of the children's carers fabricated and / or induced symptoms of ill-health in the children and pursued unwarranted medical interventions on their behalf in response to induced or imagined health problems.

The Ombudsman found that, in view of all the circumstances, the Council acted reasonably in conducting an Initial Assessment of the children before deciding whether to invoke the child-protection protocol: 'Safeguarding Children in Whom Illness is Fabricated or Induced (2008)'. The Ombudsman also found that the Council acted reasonably in deciding that, on the basis of the findings of the Initial Assessment, the invocation of the Protocol was not justified. This aspect of Ms M's complaint was therefore not upheld.

However, there was a degree of unwarranted delay in Children's Services obtaining detailed information from Ms M about her concerns, and there was a failure on the Council's part to adequately record the grounds on which its decision not to immediately implement the Protocol was based.

Further, the Ombudsman found that there were unacceptable delays in the completion of the Initial Assessment, together with failures to update and inform Ms M on the progress / outcome of the investigations conducted and subsequent decisions taken in response to her referral. These complaints were upheld.

The Council accepted the upheld elements of the complaint and has agreed to implement the Ombudsman's recommendations. The Ombudsman recommended that Ms M receive a fulsome apology for the failures to update and inform her on the progress / outcome of the investigations conducted and subsequent decisions taken in response to her referral. The Ombudsman also made recommendations with respect to the review and audit of systems for monitoring the recording and timeliness of decision-making on referrals, and with respect to the review and audit of systems for monitoring the timely completion of Initial Assessments.

Case reference 200801609

March 2011 – Assessment of Needs – Merthyr Tydfil County Borough Council

Mrs K's main complaint related to delays and inadequacies in the Council's assessment of her daughter AK's needs by its Children with a Disability Team ("the CDT") and the Occupational Therapy Team. AK (who was aged three when Mrs K complained) has complex needs and in October 2008 was diagnosed with Autistic Spectrum Disorder. Prior to approaching this office, Mrs K had formally complained to the Council under its formal complaints procedure.

In relation to the CDT, the Ombudsman's investigation as well as commenting on the failings previously highlighted following Mrs K's formal complaint to the Council (such as a delay in the carrying out of the core assessment on AK) found that the CDT could have been more proactive and intervened earlier and more effectively in AK's case. The investigation also highlighted administrative shortcomings coupled with a failure to follow statutory guidance on the assessment process.

With regards to the Occupational Therapy department, the Council had previously accepted shortcomings in the assessment process as a result of Mrs K's formal complaint to it. The Ombudsman's investigation highlighted areas of concern relating to bias and the tainting of the decision making process when it came to AK's case.

Having made findings of maladministration and upheld Mrs K's complaint, the Ombudsman made the following recommendations, to be carried out within one month of the report being issued:

- apologise to Mrs K for the shortcomings identified in the report;
- in recognition of the impact that these failings had had on Mrs K and her daughter (which extended to Mrs K being put to the time, trouble and inconvenience of having to make complaints both to the Council and this office) the Council should make a payment of £750;
- provide an action plan that addressed any shortcomings not previously dealt with following Mrs K's earlier formal complaint to the Council.

Case reference 200802477

March 2011 – Adequacy of investigations – Denbighshire County Council

Mr A complained that Denbighshire Social Services had failed to adequately investigate concerns about the care of his son X and X's three older siblings whilst they have been living with their mother Miss B. Mr A indicated that concerns had been raised by himself, by X's paternal grandparents and other agencies regarding the children's welfare. Mr A made a formal complaint about these matters in June 2008 to the Council and remained dissatisfied with Denbighshire's response to the concerns which he continued to raise.

Mr A's complaint specifically focused on three incidents which occurred between May 2008 and August 2009. Mr A said that these were not properly investigated and were viewed as isolated incidents rather than indicative of Miss B's inability to care for the children properly. Mr A believes that the Council were not impartial in their investigations and believed Miss B's explanations at face value. Mr A also said that there was inadequate communication and support to himself and his family during these periods.

The Ombudsman found that the Council did respond to referrals including those from other bodies and did take some action. However the Council's investigations were not as comprehensive as they should have been and were not considered in the context of the full circumstances of the case.

Mr A also raised concerns about school attendance of Child Y but the Ombudsman could not find any records to indicate that the Council were aware of any issues in relation to this. The Ombudsman was unable to make a judgement on this.

Overall, the Ombudsman upheld the complaint that there was inadequate investigation of the concerns raised. The Ombudsman also upheld the complaint there was no support offered to Mr A and his family during the short term 'emergency' periods that they cared for the children and indicated that arrangements should have been formalised. Feedback to Mr A and his family should also have been improved.

As a result of the investigation, the Ombudsman made the following recommendations to the Council:

- the Council should apologise to Mr A for its inadequate responses to the concerns raised and its subsequent feedback to Mr A;
- the Council should audit a selection of recent child protection referrals which did not result in a child protection case conference to ensure the robustness of the assessment and decision making processes;
- the Council should ensure the effective implementation of its more recent procedure for providing feedback to referrers and establish a robust auditing process;
- the Council should review its protocol with the Police for using powers of Police protection to ensure that appropriate arrangements are made for the accommodating of children subject to these powers;
- the Council should review its procedure in respect of the placement of children with family and friends to ensure that it is fully complying with Section 20 and 23 of the Children Act 1989 and the relevant case law.

Case reference 200901053

February 2011 – Assessment of needs – Powys County Council

Mr and Mrs W, who have two adopted sons, complained that the Council failed to undertake a statutory assessment of their needs as a family for post adoption support services. They complained further that having commenced an assessment which was limited to one of their sons, the Council delayed unreasonably in completing the assessment and thereafter failed to produce a post adoption support plan specifying his needs and the provision to meet those needs. Finally, they complained that the Council's investigation of, and response to their complaint was unsatisfactory.

The Ombudsman upheld their complaint. Whilst the Council's decision to undertake separate core assessments in respect of each child was appropriate and consistent with guidance issued by the Welsh Assembly Government, there was a failure to explain what was involved to Mr and Mrs W at the outset. Their confusion was compounded by the Council's action in embarking on an assessment which was limited to one child only, and its failure to complete the assessment within a reasonable timescale, and its failure to deal with the issues satisfactorily when Mr and Mrs submitted their complaint about the assessment process.

After Mr and Mrs W had submitted their complaint to the Ombudsman, the Council undertook and completed a fresh assessment of their sons' and their needs as a family for post adoption support, and did so within a reasonable timescale which took account of Assembly Government guidance.

The Ombudsman recommended the Council to tender its written apologies to Mr and Mrs W and to pay them £250 in respect of the injustice arising from its maladministration. The Council also undertook to complete a review of adoption support assessment procedures to prevent a recurrent of the failures and delays that occurred in this case, and to review its complaints procedures.

Case reference 200901768

Various Other Summaries

Upheld

February 2011 – Sale of land – Rhondda Cynon Taf County Borough Council

Mr N complained about the manner in which the Council has sold some of its land which had resulted in a portion of land which he indicated he had the sole use of being sold to one of his neighbours without his knowledge. The Council's view throughout a protracted complaints process was that the sale had been legally and technically correct and there had been no error made by the Council. The Ombudsman found maladministration. The Council had not followed its own procedures. The site inspection which had been undertaken was inadequate. No records had been made, nor were any measurements or photographs taken. A proper inspection would have revealed that part of the land was fenced off, and would have resulted in Mr N being consulted. In addition, whilst the Ombudsman accepted that the sale was legally correct, he found that this did not address the point of the complaint, which related to maladministration in the process.

The Ombudsman acknowledged that there were several reasons for the difficult situation in which Mr N now found himself. Whilst it could not be solely held to be the fault of the Council, its actions had contributed to the situation. The Ombudsman recommended that the Council should apologise in writing to Mr N, should pay Mr N £2000 to reflect its role in the subsequent problems he has had and his time and trouble in pursuing his complaint. In addition, the Ombudsman recommended that the Council should provide support to Mr N, should he ever require it in any future dispute over his right of way over the land.

Case reference 201000341

Not Upheld

March 2011 – Complaint-handling – Cyngor Sir Ceredigion

After bringing to the Council's attention that sensitive information could be accessed from its publically available website, Mr A expressed dissatisfaction with the way that the Council had subsequently brought the matter to the Police's attention. In addition, he felt that the Council had not properly disclosed the facts of the case and this had contributed to him being arrested by the Police. The Police had subsequently dropped all charges against him. Mr A raised other matters, some of which were considered not to fall within the Ombudsman's jurisdiction.

The Ombudsman's investigation concluded that it was not unreasonable for the Council to have referred the matter to the Police. The Ombudsman was satisfied that the Council had made the Police aware of the pertinent facts, such as the fact that the material was legally accessible on its public site and that Mr A had himself brought the matter to the attention of a Council member prior to contacting a Council officer. The Ombudsman did not uphold Mr A's complaint.

Case reference 200901216

February 2011 – Licence application – Environment Agency

Mr F complained about the Environment Agency's ("the Agency") administration of his application for a Dee cockle licence. He said that the Agency had failed to make further relevant enquires in order to validate the assessment information he had submitted in support of his licence application. In particular, Mr F was concerned that the Agency had taken additional steps to validate buyer references for other applicants but had failed to take steps to validate either his own buyer references or his tax returns. As a consequence, he says his application had not been properly ranked and he was not sufficiently highly placed for a licence to be allocated. This had resulted in a substantial loss of income for Mr F.

The investigation found no evidence of maladministration in the Agency's consideration of Mr F's licence application and the complaint was not upheld.

Case reference 200901964

More Information

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

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

Public Services Ombudsman for Wales
1 Ffordd yr Hen Gae
Pencoed
CF35 5LJ

Tel 01656 644200
Fax 01656 641199

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