

The Ombudsman's Casebook

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A word from the Ombudsman

Welcome to the third edition of The Ombudsman's Casebook. The year to date has seen a steady rise in complaints about maladministration to my office, and at the end of December, they were up by 3%. Despite this, the changes the office has made to the way we manage complaints and the hard work of my staff have seen major improvements in the number of cases we have closed and a reduction in the number of older cases.

From April, we expect a further increase in health cases because of the abolition of the Independent Review stage of the health complaints process which means that all independent reviews of NHS complaints will be undertaken by my office. It remains to be seen whether the pressure faced by bodies providing public services is reflected in increased dissatisfaction and a growing number of complaints. Given the innovative steps being taken by many bodies to protect key frontline services I am hopeful that this will not prove to be the case but I will be monitoring the statistics carefully.

The range of cases featured in this issue is very diverse, and reflects many aspects of the work of public services in Wales. In identifying themes, we have focused on a particular aspect of healthcare – the two week referral guidelines for suspected cancer. GPs are expected to refer people with symptoms defined by the National Institute of Clinical Excellence for urgent investigation, as early diagnosis is often vital in achieving good results in cancer treatment. Unfortunately, we have seen a number of instances where this has not happened and, on occasions, it is evident that the outcome for the individual might well have been better had the referral been made promptly.

We have also taken this opportunity to highlight anti-social behaviour as a common theme across many of the housing complaints received by my office. During the last quarter, more than half of the housing reports issued by my office related to anti-social behaviour in some way, and the majority of these complaints were upheld. In most of these cases, there was a failure by housing providers to take prompt and effective action. Housing providers have access to a range of measures to tackle anti-social behaviour and it is important that consideration is given to using the right intervention early enough to be effective.

Looking across the casebook does allow my office to identify issues of broader concern like this and we will of course be raising them with the relevant bodies. I hope that you will find issues here relevant to you and that you can use the lessons identified to help improve your own work. Ultimately, learning from our own mistakes helps to improve our services for the future – learning from other's mistakes helps us to avoid making them in the first place!



Peter Tyndall
Ombudsman

Lessons Learnt

Health

Failure to follow NICE and WAG guidance

During the last year, a number of public interest and other reports have been issued in which the failure of health bodies to follow various guidelines issued by the National Institute for Health and Clinical Excellence (NICE) and the Welsh Assembly Government (WAG) has featured amongst the findings.

The details of the reports issued during the last six months are provided below. As the failure to follow guidelines appears to be an increasingly familiar feature within health complaints, health bodies are encouraged to read these summaries and ensure that the appropriate guidelines are always followed.

Urgent referral of suspected cancer

In particular, health bodies should note the contents of the public interest report issued in December 2010. This report highlights the need to ensure that all GPs follow clinical guidelines for the urgent referral of cases of suspected cancer.

The report (200901952) found that a GP failed to make an urgent referral for suspected cancer within the time limit set out in the 'Referral guidelines for suspected cancer' issued by NICE. Under these guidelines, as well as other guidelines produced by WAG, the urgent referral of this type of suspected cancer should have resulted in the patient in question being seen by a specialist within two weeks of the GP's referral. However, in this case, the urgent referral was not made and the patient's cancer was not diagnosed until five months after the initial consultation. Sadly, the patient died in 2009.

Amongst other conclusions, the report stated that five year survival data compiled by Cancer Research UK suggested an earlier referral would have given the patient a better chance of recovery. This case should act as a valuable reminder to all GPs to be satisfied they are sufficiently familiar with both the NICE and Welsh Assembly Government guidelines relating to the urgent referral of suspected cancer in order to ensure that the failings identified in the above case are not repeated.

Further examples of the failure to follow NICE and WAG guidelines

The following reports provide an indication of the various NICE guidelines that health bodies have failed to follow, which have come to the attention of the Ombudsman over the course of the last six months.

In September 2010, the Ombudsman's office issued a report (200900757) in which, amongst other findings, the health body was recommended to ensure that its staff had use of an appropriate 'template incident report form' to ensure the correct recording of incidents as required by the relevant NICE guidelines.

In December 2010, the Ombudsman's office issued a report (201000098) finding that a health body failed to follow national guidelines (NICE and the National Patient Safety Agency) on falls assessment and prevention. The report recommended that the health body ensure that it has falls policies and risk assessments in place which are in line with the stated guidance.

The Ombudsman's office is also currently preparing to issue two reports concerning the extent to which public bodies followed NICE and WAG guidelines in respect of pressure ulcer management. Each of the reports relate to the care and treatment received by vulnerable patients in relation to pressure ulcers, and, in each case, the health bodies in question are found to have failed to follow the relevant guidelines. The summaries for these reports will be available in the next edition of The Ombudsman's Casebook, and health bodies are encouraged to take note of them.

Key Questions:

Have I read the relevant guidance in relation to any particular matter?

Do I have a copy of the relevant guidance?

Am I satisfied that the records demonstrate I have followed the relevant guidelines?

Do the records themselves meet the requirements of the relevant guidelines?

Housing

Anti-social behaviour

A large number of housing complaints received by the Ombudsman's office relate to anti-social behaviour in some way.

During the last quarter, the Ombudsman's office issued eight reports relating to housing matters. Of these, five reports addressed the issue of anti-social behaviour, and four of the five complaints were upheld. The reports raised a variety of concerns.

In one case, the council were found to have relied too heavily on the actions of a vulnerable tenant in dealing with the initial complaint. In a further case, a council was found to have relied overly on the complainant reporting matters to the police, rather than investigating and monitoring the problem in order to bring it to a conclusion. In the other two cases, the council's anti-social behaviour procedures did not meet the requirements of the relevant legislation.

A common theme across these complaints was that each council failed to act proactively or promptly to resolve the complaints. In comparison, the complaint relating to anti-social behaviour which was not upheld demonstrated that the council had been proactive in attempting to resolve the complaint. The steps taken by the council were also considered to have been in accordance with its own policy. As the complainant failed to engage in the process, with the result that the council had to stop its investigations, it was concluded that the council's actions were reasonable.

All councils should be mindful that they have a wide range of duties and powers in relation to anti-social behaviour occurring within a community and they must work with other organisations such as the police to address these problems. Furthermore, as landlords, councils and housing associations also have specific duties to address anti-social behaviour within the properties they manage.

Key Questions:

Is it a matter that we can/should investigate?

Have we met our duties/obligations in investigating this matter?

Have we acted promptly and efficiently?

Have we met our obligations as landlords?

Have we used all of the avenues open to us?

Are the steps we are requesting the complainant to take reasonable?

If so, do they need any assistance in taking these steps?

Have we liaised effectively with any internal or external parties in resolving this matter?

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.

December 2010 - Clinical treatment outside hospital – GP in Abertawe Bro Morgannwg University Health Board area

Mr K complained about treatment that his mother, Mrs K, received from her GP. Mr K said that the GP failed to diagnose or refer Mrs K appropriately when she presented symptoms to him. Mrs K was later diagnosed with renal cancer in hospital and sadly died. Mr K maintained that an urgent referral from the GP may have prevented her death.

The Ombudsman found that the GP should have referred Mrs K urgently after one particular consultation. During that visit Mrs K told the GP that she had passed blood in her urine and had pain in her abdomen. The Ombudsman found that the GP should have referred Mrs K to a specialist for suspected cancer. Clinical guidelines indicate that blood in the urine should lead to such a referral under what is known as “the two week rule”. This means that a patient is seen by a relevant specialist within the two weeks. By not doing so in this case, the GP made a significant error. The Ombudsman concluded that Mrs K would have had a much better chance of survival if the GP had made the referral. Therefore, whilst noting that the GP had acknowledged the matter, learned from it and apologised on various occasions, he upheld the complaint. The Ombudsman recommended that the GP apologise again and pay Mr K £3000 in recognition of the additional suffering he has endured due to the uncertainty about what outcome may have resulted from an appropriate and prompt referral.

Case reference 200901952

Upheld

December 2010 – Provision of services – Carmarthenshire Local Health Board (now Hywel Dda Health Board)

Mr X complained that the LHB had failed to provide Myalgic Encephalopathy/Chronic Fatigue Syndrome (ME/CFS) related services for his wife, Ms Y and her daughter, Ms Z. He reported that it had no specialist services for persons affected by ME/CFS. He said that it had refused to fund treatment for Ms Y and Ms Z. He reported that it had not given Ms Y any help. He stated that the services it had offered her were unable to meet her needs. He also alleged that no one had followed Ms Z's treatment plan.

The Ombudsman did not uphold those aspects of Mr X's complaint that concerned the general provision of specialist services, the funding and provision of treatment for Ms Y and the implementation of Ms Z's treatment plan. He upheld that part of Mr X's complaint related to the LHB's refusal to fund treatment for Ms Z.

He recommended that the Health Board should consider amending its Individual Patient Commissioning ('IPC') Policy and its Policy and Procedure for ME/CFS. He asked it to make every effort to ensure that all clinicians are aware of their right to appeal against its funding decisions. He recommended that it should ensure that it keeps minutes of all its IPC Panel meetings and that these minutes accurately record the decision-making process. He asked it to make every effort to ensure that the IPC Panel considers all funding applications within one month of their receipt. He recommended that it should ensure that the IPC Panel has access to appropriate clinical expertise. He asked it to apologise, in writing, to Mr X and Ms Z, for the failings identified. He also recommended that it should pay Ms Z £750 to compensate her for its failure to meet her ME/CFS-related needs. The Health Board agreed to comply with these recommendations.

Case reference 200800465

December 2010 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board

Mr A complained about the treatment provided to his late wife, Mrs A, during her in-patient stay at Wrexham Maelor Hospital. Specifically, Mr A complained that Mrs A had fallen out of bed during the night but he had remained unaware of this until after her death when he made a complaint about her care. He felt that the fall could have led to the worsening of Mrs A's condition.

The Ombudsman sought advice from one of his professional advisers. Her view was that there was no evidence that the fall had directly contributed to the deterioration in Mrs A's condition. However, she noted that the family should have been informed of Mrs A's fall at the time. She also highlighted shortcomings in the falls risk assessment and the incident investigation after Mrs A's fall. In addition, she expressed concern that the Health Board did not have a falls policy and did not appear to be fully following national guidelines on falls assessment and prevention.

The Ombudsman upheld Mr A's complaint and made recommendations to the Health Board to improve its procedures on falls management in line with the advice of the professional adviser. He also asked the Health Board to apologise in writing to Mr A for the shortcomings identified.

Case reference 201000098

November 2010 – Pain management - Cardiff and Vale NHS Trust

Mrs L complained about the way her late mother's pain was managed whilst a patient at the University Hospital of Wales, Cardiff. Mrs P had a past medical history of Chronic Obstructive Pulmonary Disease and was admitted with shortness of breath and a general feeling of being unwell. Mrs L complained that Mrs P suffered unnecessary pain and that the Health Board failed to give adequate pain relief and carry out assessments at regular intervals. Mrs L complained that there was a delay in setting up a syringe driver to deliver adequate pain relief in a timely manner. Mrs P also contracted Clostridium Difficile during her stay. Mrs L complained that the Health Board ignored infection control procedures.

The Ombudsman's investigation found that the care which was provided to Mrs P fell below a reasonable standard. The Ombudsman was critical of the actions of nursing staff as they failed to act in Mrs P's best interests when they did not adhere to the medical instructions to keep Mrs P comfortable and pain free. The Ombudsman found that there was a delay in establishing a syringe driver when Mrs P suffered severe pain. Furthermore, there was a failure to initiate infection control procedures.

The Ombudsman upheld the complaint and made a number of recommendations including that the Health Board apologise to Mrs L for the failings identified in the report; identify lessons that can be learned from the complaint to prevent a reoccurrence of the events complained of; issue a reminder to staff about maintaining good record keeping; implement an action plan to address the issue of accessing syringe drivers at short notice; and develop a policy for managing patients at the initial stages of infection.

Case reference 200900951

November 2010 – Clinical treatment outside hospital – GP in Hywel Dda Health Board area

Mr G complained about the standard of care his GP, Dr W, provided to him. He was also dissatisfied with the consultations as he felt Dr W failed to listen to him and that the consultations were rushed. He said that Dr W's failure to listen to his concerns had delayed his referral for further tests. Mr G added that following a private MRI scan that took place at his insistence, he was diagnosed with a brain tumour. Finally Mr G complained about the manner in which Dr W informed him of the diagnosis (by telephoning him at home) and the Practice's handling of his complaint.

The Ombudsman's investigation found that there were failings in the care provided to Mr G. In particular, the investigation found that the Practice failed to have regard to correspondence from a Consultant Physician asking the GP to explore Mr G's headaches, which may have resulted in a more urgent referral for an MRI scan. In light of the failings identified Mr G's complaint was upheld. The Ombudsman recommended that Dr W apologise to Mr G in writing for the shortcomings identified in the report and pay him £250 for the distress and inconvenience caused; which included the way Mr G was told of his diagnosis. The Practice was also asked to reimburse the costs of Mr G's private MRI scan.

Case reference 200901268

November 2010 – Clinical treatment in hospital – North Wales NHS Trust (now Betsi Cadwaladr University Health Board)

Mr D complained about the care provided to his late wife at Wrexham Maelor Hospital in 2006. In particular, Mr D complained that his wife was not given adequate nutritional support; that her fluid and dietary intake were not monitored (with the consequence that she was given too much fluid causing pulmonary oedema); that his wife's depression and anorexia were overlooked; that her oxygen mask was removed shortly before Mrs D's death; and that communication with him about his wife's condition was poor.

The Ombudsman partly upheld Mr D's complaints. He found that the clinicians treating Mrs D had recognised Mrs D's nutritional problems and took what steps they could to address them; however, their efforts were undermined by Mrs D's refusal to take their advice. The Ombudsman was critical of the failure to notice a major imbalance between Mrs D's fluid input and output. The Ombudsman found that consideration had been given to whether Mrs D had depression and anorexia as she was assessed by a Consultant Psychiatrist. Unfortunately, there was no adequate record of this assessment in the notes so the Ombudsman was unable to say whether the Consultant Psychiatrist's opinion was reasonable or not. The Ombudsman was critical of the failure to make an adequate note of this assessment and of other instances of poor record-keeping. The Ombudsman found that the removal of Mrs D's oxygen mask would not have caused her any harm. Finally, on the subject of communication with Mr D, the Ombudsman noted that it had been recorded in the notes on two occasions that Mrs D did not want her care discussed with Mr D. However, on other occasions she did allow Mr D to be involved in discussions about her care. The Ombudsman concluded that the Trust could have done more to satisfy itself about what Mrs D's wishes actually were.

The Ombudsman recommended that Betsi Cadwaladr University Health Board (as successor to North East Wales NHS Trust) should apologise to Mr D for the failings identified and pay him £750 in recognition of the time and trouble he was put to in pursuing the complaint. He also made a number of recommendations aimed at improving processes at the Hospital.

Case reference 200901231

November 2010 – Clinical treatment in hospital – Gwent Healthcare NHS Trust (now Aneurin Bevan Health Board)

Mrs A complained about the standard of treatment and care provided by the Trust (now Local Health Board) after a fall on steps outside her home. Mrs A said that the Trust failed to diagnose a fractured pelvis. Consequently, she was given inadequate pain relief and inappropriate treatment advice.

The Ombudsman partly upheld Ms A's complaints. He found that Mrs A's clinical care was managed satisfactorily by the physicians and that the treatment decisions and advice given were appropriate to her presenting condition. However, the standard of pain management and discharge planning fell below that which would reasonably be expected. There was also a lack of proper recording of the nursing care and assessments that would have dealt with these matters. As a consequence, Mrs A was poorly prepared for her discharge home and was left with unmet needs.

The Ombudsman was critical of the Trust's complaint investigation which was not informed by any consideration of Mrs A's nursing care. He recommended that the Health Board should apologise to Ms A for the failings identified and that it pay her £250. The Health Board also agreed to review and identify improvement measures to address the shortcoming in A&E nursing practice identified by the investigation.

Case reference 200801859

November 2010 – Clinical treatment in hospital – Cardiff and Vale University Local Health Board

Ms L complained about the standard of care and treatment provided by the Health Board following an ankle injury. Ms L complained that the doctor she saw in Accident and Emergency (A&E) was rude, did not examine her properly, and wrongly told her to stop using crutches. Ms L complained that there were then delays in diagnosing that she had fractured her ankle and in arranging physiotherapy. She also complained that the Health Board took too long to respond to her complaints.

The Ombudsman partly upheld Ms L's complaints. He was unable to say whether the A&E doctor had been rude as it was Ms L's word against the doctor's. On balance the Ombudsman found it likely that the A&E doctor had carried out some sort of examination, but he was critical of the advice given to Ms L that she should stop using the crutches. The Ombudsman noted that Ms L's ankle fracture was not visible on the X-rays that were taken and that it was not until an MRI scan was done that it could be diagnosed. The delays in Ms L receiving physiotherapy were regrettable but the Ombudsman could not say that the Health Board was responsible for the delay. Finally, the Ombudsman criticised the Health Board's delay in responding to Ms L's complaints. He recommended that the Health Board apologise to Ms L for the failings identified and that it pay her £50 in recognition of the time and trouble she was put to in chasing responses to her complaints.

Case reference 200902367

November 2010 – Clinical treatment in hospital – North Wales NHS Trust (now Betsi Cadwaladr University Local Health Board)

Mrs T complained about the care and treatment provided to her by the former North Wales NHS Trust. She complained about the conduct of a clinical psychologist who had been providing her with individual therapy sessions. She subsequently complained about the Trust's handling of her complaints, the Trust having investigated the clinical psychologist's conduct confidentially under its internal disciplinary procedure.

The Ombudsman found that the Trust had acted appropriately with respect to the provision of therapy and had re-evaluated Mrs T's care reasonably. The Ombudsman concluded that the Trust had failed to deal adequately with the NHS aspects of Mrs T's complaint, both in terms of timeliness and substance, and he found that inadequate information had been provided about the investigation of the clinical psychologist's conduct. The Ombudsman recommended that the LHB apologise to Mrs T for its inadequate handling of her complaint and make a payment to her of £250 in recognition of that failing. The Ombudsman also recommended that the LHB provide further explanations to Mrs T in response to the NHS aspects of her complaint and further information about the possible outcomes of the disciplinary process.

Case reference 200900726

November 2010 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Local Health Board

Mr H complained that the Health Board failed to handle his complaint in accordance with its published complaints procedure, by failing to acknowledge receipt of all correspondence and failing to complete its complaint investigation in a timely fashion. Mr H also complained that responses were inadequate and that there was a significant delay in a comprehensive reply being issued.

The Ombudsman found that the Health Board had indeed failed to deal with Mr H's complaint properly and that not only had it failed to adhere to its complaints procedure in respect of timescales, the delays Mr H experienced were far in excess of what could be considered reasonable under any circumstances.

The Ombudsman recommended that the Health Board should apologise to Mr H and provide details of what action it had taken (and was continuing to take) in order to address the administrative failings identified.

Case reference 201000049

November 2010 – Clinical treatment in hospital – Hwyl Dda NHS Trust (now Hwyl Dda Health Board)

Mr A complained that his partner Ms B was administered an anticoagulant drug and died following a large cerebral bleed. Mr A complained that the medical staff did not explain the risk of such bleeding associated with the anticoagulant treatment either to him or his partner and therefore considered that they had been denied their right to be involved in the decision making process. Mr A indicated that had the risks been explained that the treatment would have been refused. Mr A also raised in the complaint that an allergic reaction to antibiotic treatment may have been a contributory factor in Ms B's death. Mr A also complained about the way a doctor spoke to him prior to his partner's death.

The Ombudsman did not uphold the complaint about the clinical management of Ms B's condition including the administration of anticoagulant medication. However, the Ombudsman did uphold the complaint about the communication between the Health Board and Ms B's family and friends. He concluded that communication could have been improved particularly about the nature of Ms B's condition and the effects of anticoagulant treatment. He was unable to determine whether the doctor had been rude.

The Health Board agreed to implement the Ombudsman's recommendations regarding communication and the need for staff to be reminded of the rights of patients, family members and others in emergency situations.

Case reference 200802295

November 2010 – Handling of complaints – North Wales NHS Trust (now Betsi Cadwaladr University Local Health Board)

Ms S complained that the Trust did not investigate an assault allegation that she made against a member of its staff properly. She told us that the Trust ignored her account of this alleged assault. She said that she was dissatisfied with the outcome of the investigation completed by the Trust. She also indicated that she was dissatisfied with the Trust's response to her formal complaint about this matter.

The Ombudsman upheld Ms S's complaint. He recommended that the Board should, when developing its new complaints policy, consider its management of informal complaints in an effort to address some of the failings identified. He asked the Board to ensure that all relevant staff members receive further training, about the management of informal complaints, with reference to his report and its new complaints policy. He recommended that the Board should send Ms S a copy of its new complaints policy and details of the training arrangements made. He extended the compliance periods for these recommendations because he recognised that the Board might not be able to comply with them, within shorter timescales, due to national developments related to complaint handling. He asked the Board's Chief Executive to write to Ms S to apologise for the Trust's failings and to confirm the Board's willingness to comply with his recommendations. The Board agreed to comply with all of the Ombudsman's recommendations.

Case reference 200900060

November 2010 – Delay in treatment – Abertawe Bro Morgannwg University NHS Trust (now Abertawe Bro Morgannwg University Health Board)

Mr C complained about the delay in providing him with Continuous Positive Airway Pressure (CPAP) treatment when he was diagnosed with severe Obstructive Sleep Apnoea. He said that this resulted in his having to seek treatment privately when his condition deteriorated. He eventually purchased a CPAP machine at his own expense.

The Ombudsman found that Mr C waited a considerable time following his diagnosis (well over a year) when no treatment was offered to him. It was noted that there were some funding problems at the time. However, the Ombudsman expressed concern that there was a lack of initial communication with Mr C outlining the diagnosis and the management plan for his condition. There was then no further communication with Mr C to keep him updated about the delays. In addition, there was doubt as to whether Mr C had been afforded the correct priority for treatment. The Ombudsman upheld Mr C's complaint and, taking into account the specific circumstances of this complaint, the Ombudsman recommended that the Health Board reimburse Mr C for the cost of the CPAP machine that he purchased.

Case reference 200900823

Not Upheld

November 2010 – Clinical treatment in hospital – London Women's Clinic Swansea

Mrs B complained about the London Women's Clinic Swansea ("the Clinic") where she had undergone two NHS funded cycles of fertility treatment in January and May 2006. In particular, she complained that the Clinic had: failed to perform a Follicle Stimulation Treatment (FSH) test before treatment began; failed to advise her, or her partner, about the prospects of success so that they could make an informed decision or choice about treatment; and it had failed to provide them with information about the side effects of a drug prescribed (Puregon) which they complained led to Mrs B suffering painful bloating (that they believed to be Ovarian Hyper Stimulation Syndrome - OHSS) and had caused Mrs B's miscarriage.

Having sought clinical advice, the investigation found that whilst it was good practice for Clinics to undertake an FSH test before In vitro Treatment (IVF) treatment, it is not a mandatory requirement. Any failure to perform the test did not affect the outcome as other assessments had been undertaken, and a successful pregnancy followed the second cycle of treatment (albeit, sadly, Mrs B miscarried early on in the pregnancy). Whilst the information provided by the Clinic at the time confined its statistics to successful pregnancies (as Mrs B's was classified), and not live birth rates, there was no evidence to show that this had affected the decision to continue with treatment, or the outcome. The Clinic had given advice about the side effects of the drug used in the treatment, although there was doubt about the certainty of advice regarding obtaining further supplies of another drug. There was no clinical evidence to show that Mrs B suffered from OHSS, or that Puregon was responsible for her bloating or the miscarriage. The Ombudsman did not uphold the complaint but asked the Clinic to review its information leaflet about obtaining the supplies of further treatment drugs.

Case reference 200901988

November 2010 – Clinical treatment outside hospital – GP in Aneurin Bevan Health Board area

Mr A complained that his GP had failed to diagnose and treat his rosacea promptly and effectively. He said that the GP failed to examine his nose, refused to refer him to a dermatologist and failed to prescribe antibiotics despite several consultations during January and February 2009.

The Ombudsman's clinical adviser concluded that Mr A received appropriate treatment at a reasonable time, and that Mr A's perception of the seriousness of his complaint did not accord with that of the doctors in the surgery or consultant dermatologists to whom he was referred. The Ombudsman did not uphold Mr A's complaint.

Case reference 201000065

October 2010 – Clinical treatment in hospital – Cardiff and Vale University Local Health Board

Mr A suffered a cardiac arrest in November 2008. He was resuscitated by paramedics and admitted to the University Hospital of Wales. Mr A sustained brain damage due to the shortage of oxygen to his brain; he had extremely poor short-term memory, was prone to wandering, was sexually

disinhibited and tended to speak about events which had not happened. At first the intention was to transfer Mr A to a specialist rehabilitation facility. However, there was no bed available in the unit at the time, and it became more difficult to retain Mr A on the ward as his physical health improved. In January 2009 Mr A was transferred to a neurological ward, where he received additional nursing input, and was regularly reviewed by neuro-rehabilitation specialists. Mr A was seen by a psychiatrist, as well as occupational therapists and physiotherapists. In March 2009 it was decided that Mr A was not suitable to be transferred to the specialist unit, and he remained on the neurological ward until September 2009 when he was discharged to a specialist nursing home. Mr A junior complained about the failure to transfer Mr A to the specialist unit, the fact that Mr A had been able to leave the hospital unaccompanied, and also about what he believed were failings in communication between the professionals involved in Mr A's care and his family.

The Ombudsman, assisted by clinical advice which he received, concluded that it was appropriate to have transferred Mr A to the neurological ward pending a bed becoming available at the specialist unit, and also that it was reasonable to have amended this plan when it became clear that Mr A would be unlikely to benefit from being at the unit. He had received appropriate medical therapies, and the outcome for Mr A would, sadly, have been unlikely to have been significantly different had he been admitted to the specialist unit or received any alternative or additional therapies. The Ombudsman concluded that at the time Mr A left the hospital staff had not been legally able to detain him. The Ombudsman noted that there was evidence in Mr A's clinical records of meetings and discussions with members of Mr A's family.

The Ombudsman did not uphold the complaint.

Case reference 200901461

October 2010 – Continuing Care – Abertawe Bro Morgannwg University Local Health Board (LHB)

A solicitor complained on behalf of Mrs W about the LHB. The solicitor said that the LHB's continuing care Independent Review Panel ("IRP") did not make decisions appropriately in relation to Mrs W's mother, Mrs A. This resulted in the IRP confirming two original decisions that Mrs A was not eligible for continuing care for various periods. The solicitor's main points concerned the IRP not having an accurate assessment of Mrs A's condition and not making the decisions in the correct manner.

The Ombudsman found that the IRP did have an accurate appraisal of Mrs A's condition available. With one point of exception, the Ombudsman concluded that the IRP had conducted its decision making without error. The Ombudsman did not uphold the complaint.

Case reference 201000035

October 2010 – Continuing Care – Powys Teaching Local Health Board & Aneurin Bevan Local Health Board

Mr W complained that in considering a retrospective claim for NHS funded continuing care costs, in respect of his late mother's care home fees, the two LHB's failed to properly apply the relevant criteria and guidance.

The Ombudsman found that the claim had been properly considered and that the conclusions reached were reasonable, logical and well supported by evidence from her medical and care home records. The Ombudsman therefore did not uphold Mr W's complaint.

Case reference 200901454 & 200901395

Planning and Building Control Summaries

Upheld

December 2010 - Handling of planning applications – Carmarthenshire County Council

Mrs A complained that Carmarthenshire County Council failed to properly consider her objections to a planning application for a residential development abutting her property. She stated that in granting planning permission the Council failed to protect her rights and supported trespass over her property. Subsequently, Mrs A said the Council failed to enforce a condition of the planning permission which stated that the rear windows of the development should only open four inches. Mrs A made a formal complaint about these matters and complained of unreasonable delay in the Council's response.

The Ombudsman did not uphold the aspect of the complaint relating to planning conditions. The evidence indicated that the Council did consider objections and a condition was imposed relating to the fitting of obscure glazing. It was some time later following resident concerns that the developer voluntarily agreed to put in place window restrictors. It was also found that the Council had adopted its usual approach in measuring acceptable distance between the residential properties and the flat development. As there was not a planning condition imposed relating to window restrictors then this could not be enforced by the Council. However, the Ombudsman did uphold the complaint about the Council's handling of Mrs A's complaint in terms of timeliness and confused response.

The Council agreed to implement the Ombudsman's recommendations regarding a review of its handling process for the management of complaints about planning issues and agreed to provide an apology for its failings and in light of this make a payment of £50 to Mrs A.

Case reference 200902048

November 2010 – Handling of planning application – Rhondda Cynon Taf County Borough Council

The complainant, Mr G, erected a front porch at his home. He claimed that he did so after being informed by the Council that planning permission was not required. He complained that the Council was unreasonable when it subsequently invited him to submit a planning application only to then refuse the application. He complained further that the Council threatened him with enforcement action unless he submitted an appeal against the refusal of planning permission within two weeks.

Mr G eventually submitted appeals against the refusal of planning permission and against the enforcement notice. The appeals were dismissed and the Council issued legal proceedings against Mr G in respect of his failure to comply with the enforcement notice. He demolished the porch before the Court hearing and the proceedings were withdrawn. He said he had repeatedly asked officers for a site meeting but none was held until the day after he demolished the porch, when he was informed that the porch was only marginally higher than his permitted development rights. It was explained to Mr G that the Ombudsman was unable to consider the Council's decision to refuse his planning application or to issue an enforcement notice, as Mr G had exercised his right to appeal to the Planning Inspectorate.

However, the Ombudsman found that the Council had acted unreasonably in failing to communicate adequately with Mr G at an early stage in the process, and that it was unreasonable to have solicited and refused his planning application without first discussing the matter with him at a site meeting. Mr G's complaint was, therefore, partially upheld.

The Ombudsman recommended that the Council offer Mr G a suitable apology and reimburse him the planning application fee.

Case reference 200901318

November 2010 – Unauthorised development – Bridgend County Borough Council

Mr HM complained that the Council had failed to enforce a planning condition attached to its 2004 planning permission resulting in a private lane being used by unauthorised traffic.

Councils have a discretionary power to determine whether to take any enforcement action for a breach of a planning condition. The complaint was partially upheld due to the Council's failure to properly consider its options for enforcement action and in the length of time the Council took to resolve the issue.

During the investigation of this complaint and in considering any remedial action, I considered the detriment caused to the complainant and the extent of the Council's maladministration as any recommended action has to be appropriate and proportionate.

The appropriate measures have now been put in place to address the complaint and the Council has agreed to apologise to the complainant and to make a time and trouble payment to Mr HM for pursuing the complaint.

Case reference 200901068

October 2010 – Building Control – Flintshire County Council

Mrs M was granted planning permission to build a loft conversion based on an approved set of plans ("The Approved Plans"). Part of the construction involved a roof overhang of 15cms. Mrs M complained that there had been a delay in the Council informing her that the overhang as built would not only contravene the Approved Plans but would be unacceptable (due to its size) in planning terms. Mrs M highlighted that the Council had carried out enforcement visits (for other unauthorised work) in the July and August 2008. However, the overhang had only been raised with her as an enforcement matter in December 2008, when works to the overhang were advanced and the costs of remedying the unauthorised work was considerably more than if the matter had been raised with her in August 2008.

The Ombudsman's investigation found that the problem with the overhang had only been raised with Mrs M in December following receipt of an objection to Mrs M's retrospective planning application. As well as commenting on the application, the objector had also raised concerns about the overhang. The investigation also concluded that there could have been better liaison between the Council's Planning Department and Building Control Department.

Amongst the Ombudsman's findings was that the delay in the Council formally notifying Mrs M that it would take enforcement action in relation to the overhang was maladministrative. The Ombudsman was also critical of the Council's position (which was at odds with its enforcement policy and procedure), that it only considered enforcement action when a complaint was made. The Ombudsman recommended that the Council should apologise to Mrs M for the failings.

In addition, within three months of the report being finalised, the Council should negotiate a settlement payment with Mrs M that reflected the difference between what it would have cost to reduce the size of the overhang in August 2008 and, any reasonable costs that were subsequently incurred because of the delay. In the event of dispute, the Council was to cover the costs of the appointment of an independent arbitrator (mutually acceptable to both parties) who would decide on an appropriate settlement figure.

Case reference 200802017

Not Upheld

December 2010 - Handling of planning applications – The Vale of Glamorgan Council

Mrs A complained that Council had been biased in its consideration of successive planning applications for a scheme of development at a property neighbouring her own. Mrs A said that the Council had failed to properly consider her objections to the development and its impact on the open aspect of her property. The development proceeded out of accordance with the permissions given and the Council decided not to enforce against the breach. She felt that the Council's failure to take enforcement action had allowed her neighbours to build a scheme similar to that which they had previously applied for and been refused. She was also dissatisfied with the Council's response to her complaint about the matter.

The Ombudsman did not uphold the complaint. He found that Mrs A's objections were either properly considered or were not factors that the Council could have taken into account. Whilst the investigation identified some poor administrative practice, there was no evidence of impropriety by its officers and this did not undermine the discretionary decisions that were taken. The Ombudsman also considered that the Council had taken reasonable steps to provide Mrs A with an appropriate response to her complaint.

Case reference 200900059

October 2010 – Handling of planning application – Powys County Council

Mr A and Ms B complained about the Council's management of a planning application. They said that the Council had failed to notify them of this application, by letter, despite the fact that their property bordered the development site. They reported that this development had been built on land that is approximately ten feet (3.084 metres) above the ground level of their property. They described it as being "very large and very imposing." They said that it has a balcony which allows their property to be overlooked. They told us that the Council failed to consider the impact of this development upon their privacy when determining this planning application. They also stated that the actual position of this development does not comply with the approved location plan.

The Ombudsman did not uphold those parts of Mr A's and Ms B's complaint that concerned the Council's alleged failure to notify them by letter and to consider the impact of the development upon their amenity. The Ombudsman asked the Council to write to Mr A and Ms B, regarding their concern about the location of the development, as built.

Case reference 200901204

Housing Summaries

Upheld

December 2010 – Repairs and Maintenance – Gwynedd Council

Miss T and her partner own a property. In July 2005, they agreed to participate in a Group Repair Scheme (the GR Scheme) (funded by the Council via a Welsh Assembly Grant). The council was responsible for monitoring the work of its appointed contractor for the Scheme. Miss T said she had complained repeatedly to the council about the contractor's poor workmanship. Amongst the problems she highlighted was that the roof had not been properly sealed and this had caused water damage to the interior of the property. In 2008, Mr H (Miss T's stepfather) complained formally to the council about the contractor's sub-standard work. Mr H also complained that the council had failed to follow its own complaints procedure.

The Ombudsman's investigation concluded that the council's failure to adequately monitor the contractor's work was maladministrative. The Ombudsman also found that the council did not deal with Mr H's complaint as effectively as it should. The complaint was therefore upheld.

The Ombudsman recommended that the council should complete the work that the Ombudsman's Adviser had identified as outstanding at no cost to Miss T. The Ombudsman also recommended that the council's Chief Executive should apologise to Miss T for the failings identified during the course of the investigation, and pay Miss T £2500 in recognition of the distress, inconvenience and financial loss caused to her as a result of the council's failings. In addition the Chief Executive should apologise to Mr H for the council's shortcomings in its complaints handling which had also caused Mr H inconvenience and distress and in recognition of this make a payment of £500.

Case reference 200900281

December 2010 - Neighbour disputes and anti-social behaviour – Cardiff Community Housing Association Ltd

Miss W complained that Cardiff Community Housing Association ("CCHA") had failed to deal with her complaints of anti social behaviour, against her neighbour Mrs T and Mrs T's ex partner Mr C, in an appropriate and timely manner. Miss W also complained that, in responding to a formal complaint she had made about the matter on 29 January 2009, CCHA had failed to adhere to its own complaints procedure. Finally, Miss W expressed her concern about the quality of CCHA's communication with her whilst it investigated her complaints.

The Ombudsman found that CCHA had conducted itself in accordance with its own anti social behaviour procedure when dealing with the anti social behaviour complaints Miss W made in 2007. However it was recognised that CCHA's actions were not proactive and had relied heavily on the actions of Mrs T, someone it considered to be a vulnerable tenant. Additionally, despite having the evidence available to support action being taken against Mr C directly there was no evidence that it had considered those options before pursuing Mrs T. Finally, CCHA failed to write to Miss W informing her of its decision not to pursue legal action.

With respect to Miss W's anti social behaviour complaint in 2009, the Ombudsman found that CCHA's decision to consider it as a fresh complaint was reasonable, because CCHA had not received any complaints of anti social behaviour for approximately one year. However, it was noted that CCHA had failed to provide Miss W with a written response to her formal complaint, and had relied solely on the Anti Social Behaviour Officer's response to the issues.

The Ombudsman partly upheld Miss W's complaint and recommended that CCHA issue Miss W with an apology with respect to the maladministration found. He recommended that CCHA provide training to all members of its staff on anti social behaviour and the options available when resolving complaints, and monitor the communal doors of the block of flats in question for further evidence of vandalism and criminal damage. He also recommended that CCHA ensure that the front and rear of the flats in question are made secure against intruders, and that CCHA monitor the flats for signs of anti social behaviour for a further 12 months. Finally, the Ombudsman recommended that CCHA amend its Nuisance and Anti-Social Behaviour Policy / Procedure to reflect the changes to the procedure outlined in its response to the draft report.

Case reference 200802383

December 2010 - Applications, allocations, transfers and exchanges – Cardiff County Council

Mrs A reported that the Council had prioritised her housing application. She indicated that it had done so because of her family's health needs. She noted that her husband, Mr A, had a fractured spine. She complained that the Council was taking too long to provide accommodation for her family given the priority status of her housing application. She also alleged that the Council had failed to respond to her racial abuse concerns.

The Ombudsman partly upheld the aspect of Mrs A's complaint that concerned the Council's response to her family's housing needs. He considered that the Council had not managed Mrs A's housing application properly for three reasons. Firstly, the Council's allocation policy was unreasonable. Secondly, the Council took too long to award Mrs A's housing application priority status. Thirdly, Mr A's medical assessment did not trigger the Council's homelessness duties. The Ombudsman acknowledged that it was not possible to establish that Mrs A's family would have obtained suitable accommodation more quickly in the absence of these failings. However, he concluded that Mrs A had suffered some injustice because of them. He did not uphold the racial abuse element of Mrs A's complaint.

The Ombudsman noted that the Council had amended its allocation policy. He recommended that the Council should apologise to Mrs A for some of the failings identified. He asked the Council to satisfy itself that its system for responding to housing-related medical referrals is efficient and prompt. He also advised the Council to satisfy itself that it complies with the relevant guidance when considering the housing needs of people who need to move on medical and welfare grounds. The Council agreed to comply with all of these recommendations.

Case reference 200802198

November 2010 – Repairs and maintenance – The Vale of Glamorgan Council

Ms O complained that the Council had not dealt adequately with outstanding disrepair matters at her former property, for example she noted that her front door was insecure and a water leak from an upstairs flat was affecting her property. She was also dissatisfied with the Council's delay in responding to her complaint letter.

During the course of the Ombudsman's investigation it became apparent that there were conflicting accounts between Ms O and the Council as to what was and was not said in relation to the disrepair matters raised by Ms O. The Ombudsman was unable to reconcile these accounts and made no finding. In terms of complaints handling, the Ombudsman concluded that the Council had been maladministrative in the way that it had dealt with Ms O's complaint. In recognition of the delay in dealing with Ms O's initial complaint, the Council agreed that it would apologise to Ms O and make a payment to her of £150.

Case reference 200901298

November 2010 – Neighbour disputes and anti-social behaviour – The Vale of Glamorgan Council

Mr and Mrs P complained that the Council failed to investigate their complaints about the anti-social behaviour of the family of the next door tenant. They said that the procedures published in the Council's anti-social behaviour (ASB) policy had not been followed.

The Ombudsman found that the Council's published procedures were not sufficiently detailed and that overall the Council's dealings with Mr and Mrs P were not helped by the lack of a detailed 'step by step' procedure. In particular the Council had failed to make sufficient enquiries or take legal advice about incidents which occurred during a twelve month period when a Notice Seeking Possession was in place for the neighbouring tenancy. Subsequent complaints about their neighbour's sons' behaviour were also not properly investigated, as they arose, by interviewing the complainants, witnesses or the tenant. There was a failure to act promptly and to consider the options open to the Council, other than repossession of the tenancy, as mentioned in its published ASB policy. There was also an absence of consistent reasoned recordings to explain housing officers' assessments and subsequent decisions not to take action.

The Council agreed to apologise to Mr and Mrs P, to pay them £750 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 200900909

November 2010 – Neighbour disputes and anti-social behaviour – The Vale of Glamorgan Council

Mrs Y, who is an owner occupier, complained that the Council failed to investigate her complaints about the antisocial behaviour of a neighbouring family. She said that it had not complied with its anti-social Behaviour (ASB) policy.

The investigation found that the Council did not have ASB procedures in place as required by the legislation, which was maladministration. There was also no evidence that Mrs Y's complaints had been properly explored with her or that appropriate enquiries had been made with the neighbouring tenant and her sons about their behaviour. This had not been helped by the absence of a detailed step by step procedure to deal with such complaints. In responding to the Ombudsman the Council maintained that Mrs Y was not independent and was influenced by another neighbour but it had made no effort to look at alternative ways to help her bring forward her complaints or to establish her independence.

The Council had already agreed to review its ASB policy and procedures following an earlier similar complaint. It also agreed to apologise to Mrs Y and pay her £250 for the uncertainty of not having had her complaints properly investigated. It undertook to ensure that all future complaints would be properly investigated.

Case reference 200901816

November 2010 – Applications, allocations, transfers and exchanges – Flintshire County Council

Mr X complained about the Council's administration of his application for a housing transfer and its investigation of his complaints of anti-social behaviour. Mr X said that the Council failed to consider the seriousness of his situation and had failed on numerous occasions to reply to his correspondence. Mr X was also dissatisfied with the Council's response to his formal complaints about the matter.

The investigation found that the Council had not dealt with Mr X's complaints of anti-social behaviour in accordance with its policy and procedure. The Council had relied overly on Mr X reporting matters to the police and did not properly investigate, monitor or bring the case to a clear conclusion. There were also a number of occasions when the Council did not acknowledge or provide an adequate response to Mr X's correspondence. Whilst these failings did not detrimentally affect Mr X's housing application, the Ombudsman was disappointed that they had not been identified by the Council when considering Mr X's formal complaint. The Council agreed several recommendations to review and improve its practice and also to apologise to Mr X and make him a redress payment of £250.

Case reference 200900015

November 2010 – Tenancy rights and conditions – The Vale of Glamorgan Council

Mrs T, who is a tenant of the Council, complained that the Council had imposed charges for services she did not use. She complained that the Council wrongly decided that her home was part of an adjacent block of sheltered accommodation and that she was being incorrectly charged for services associated with that sheltered housing scheme.

The Ombudsman found that the Council's decision to consider Mrs T's home part of the sheltered complex was not unreasonable. However, there had been maladministration in that Mrs T's original tenancy offer letter had incorrectly stated that the property was "non-sheltered". In addition, when Mrs T's daughter queried the service charges, she was on one occasion told by a Council officer

that the service charges would no longer apply. The Ombudsman also criticised the Council for the length of time it took to provide Mrs T with a definitive answer about whether her home was linked to the sheltered housing scheme. The Ombudsman found that the maladministration he had identified had caused Mrs T some injustice in that she had no reasonable expectation she could use the facilities for around 12 months and she and her daughter had had to chase a definitive response from the Council. The Ombudsman partially upheld the complaint. He recommended that the Council should apologise to Mrs T, reimburse 12 months of service charges, and pay Mrs T an additional £250 to reflect the time and trouble she had been put to.

Case reference 200902003

October 2010 – Repairs and Maintenance – Pembrokeshire Housing Association Ltd.

Ms S complained that Pembrokeshire Housing Association ('HA') had been unwilling to carry out repair work to faulty lighting in the bathroom and two bedrooms of her former HA property. This was despite Ms S providing evidence that the faulty lighting was not related to the improvements (namely a loft conversion) that she had carried out with the HA's permission.

Ms S also complained about the breakdown in the relationship between herself and staff in the area office and cited various examples. Having eventually paid for the repair work herself, Ms S detailed the impact that the disrepair had had on her family and said that it had contributed to her giving up her tenancy.

In response to the Ombudsman's investigation, the HA accepted that it should have carried out the repair. It also acknowledged that it had not acted on the evidence that Ms S had provided. The investigation also highlighted administrative shortcomings. This led to a finding of maladministration. However, the Ombudsman was unable to comment on Ms S's allegations of victimisation by certain HA staff.

The HA accepted the Ombudsman's recommendation that it pay Ms S a figure of £500 to properly reflect the inconvenience and distress caused to her. This figure was in addition to the settlement figure that the HA had offered Ms S at the start of the Ombudsman's investigation where it had agreed to reimburse Ms S's repair costs of £213.44 and to pay her a figure of £250 for distress and inconvenience.

Case reference 200901271

Not Upheld

October 2010 – Neighbour disputes and anti-social behaviour – Cardiff County Council

Mr T said that he had been subjected to excessive and unacceptable levels of noise from a neighbouring flat. Mr T complained that the Council had failed to adequately investigate his complaints about the noise.

Mr T's complaints about the noise from his neighbours flat were considered by both the Council's Housing and the Noise and Air Pollution Control Departments, and both departments started the investigation process in an attempt to resolve Mr T's complaints. The Council invited Mr T to a number of meetings in an attempt to gather more information about his complaint, and also asked Mr T to complete noise nuisance diaries; this part of the investigation process provided the Council with the evidence it needed to determine the most appropriate course of action.

However, Mr T did not engage in the process, and the Council had to stop its investigations, because, without Mr T's assistance and evidence, it was unable to continue an investigation into the complaint. It was felt that the Council's actions in concluding its investigation at such an early stage were reasonable, because it did not have the necessary evidence to justify continuing the investigation. Additionally, the Council's actions were in accordance with its own policy. In view of the above, the complaint was not upheld.

Whilst the complaint was not upheld, it was recognised that Mr T felt affected by the noise coming from his neighbour's flat, and the Council was asked to arrange to meet with Mr T and discuss both his complaint, and the investigation process as well as provide him with noise nuisance diaries. The Council was also asked to make an officer available to Mr T in order to answer any questions that he may have on the investigation process, or the noise nuisance diaries.

Case reference 200901080

Environment and Environmental Health Summaries

Upheld

December 2010 - Noise and other nuisance issues – Conwy County Borough Council

Mr C complained that the Council failed to enforce either of the two noise abatement notices it had served on a visitor attraction with a restaurant/function room operating near to his property. Mr C also complained that the Council's planning and licensing departments had not liaised with each other. He said that an example of this was that an entertainment licence had been granted to the visitor attraction despite it having no planning permission at the time. Mr C said that as a result of the maladministration he alleged on the part of the Council, he had suffered frequent noise disturbance since the granting of the entertainment licence for the visitor attraction in 1999.

The investigation found that the Council had not acted unreasonably or with maladministration in not enforcing the noise abatement notices. The investigation did however find maladministration in the delay on the part of the Council in agreeing an Operational Management Plan, which was a condition of the planning consent, in respect of the visitors' attraction. The Council agreed to apologise to the complainant in respect of the delay.

Case reference 200901332

Not Upheld

November 2010 – Flooding – Powys County Council

In conjoined complaints submitted by their advocate against Powys County Council ("the Council"), three residents of an estate ("the residents") complained that for some time they had suffered flooding to their gardens during heavy rainfall; both of water and sewerage. Despite complaints to the Council, the unpleasant problem had remained a source of concern for many years.

The investigation found that some work to be carried out by the Council in the summer of 2007, to mitigate the effects of surface water flooding (for which it bore responsibility), was not undertaken as a works order for the contractors had "been mislaid". That work was completed in early 2008. The Ombudsman found this to be maladministration, for which no apology or explanation had been given at the time, or since. Evidence revealed the root cause of the problem to be sewerage emanating from the adopted public sewer, following a developer wrongly joining up two drainage systems during the construction of a nearby property. The responsibility for maintenance/ repair of the public sewer rested with Dŵr Cymru which could have taken action against the developer sooner, once the source of the problem was identified, to force its rectification. Only tackling the root of the problem would provide a final solution; this was not something the Council was responsible for, and neither did it have powers to enforce those that were. Remedial work was finally completed during the investigation, in June 2010.

In partly upholding the complaint the Ombudsman recommended that the Council apologise to the residents for the maladministration and its original delay in carrying out work regarding the surface water, which the Council agreed to do.

Otherwise, the Ombudsman did not uphold the residents' complaint as the primary problem was not caused by the Council, and neither was it responsible for putting it right. Evidence showed that individual officers at the Council had done their utmost in negotiating with others to try to get the matter resolved as quickly as possible.

Case reference 200902273, 200902275 & 200902276

October 2010 – Pollution and pollution control measures – Environment Agency

Mr B complained that the Environment Agency failed to take action over many years in relation to unauthorised sewage effluent discharges from a private sewage treatment plant which had served a development of 17 dwellings. In particular he complained that the Agency failed to require the residents to connect to a nearby sewage pipeline, failed to obtain and analyse samples of discharge from the plant since November 2003, and failed to take enforcement action against the residents. As a consequence, his land was contaminated.

Mr B's complaint was not upheld. The plant had been the subject of a discharge consent issued by the former National Rivers Authority in 1994 to a management company which had not, in the event, been formed. The circumstances leading to the grant of the consent discharge were not investigated owing to the passage of time. The Ombudsman concluded that the Agency's actions over the years in treating the consent as validly granted were not unreasonable in the circumstances. There were disputes between the residents themselves, and between the residents and landowners on which the plant was located. Nevertheless, the Agency had worked with the residents, the landowners, the local authority and Welsh Water to secure a more sustainable solution, namely the connection of the development to an adopted sewer. In the meantime, it had documented its attempts to obtain samples for analysis over the years, and its records indicated the difficulties encountered in obtaining samples. Nevertheless, it had monitored the quality of the water in a nearby watercourse. The Agency's decision not to take enforcement action was consistent with its enforcement policy, and its role in ensuring no harm to the environment, in this case, the nearby watercourse. The Agency had also responded in a reasonable manner to the complainant's correspondence and that from his solicitors and other agents.

Case reference 200901321

Education Summaries

Not Upheld

October 2010 – Access to education – Neath Port Talbot County Borough Council

Ms G complained that the Council failed to provide her daughter with home education when she was unable to attend school following an incident there. The Council provided the Ombudsman with its policy on education outside the home setting from which it was clear that Ms G's daughter did not meet the criteria for home education. The Ombudsman concluded that the Council had made reasonable efforts to assist Ms G in accessing education for her daughter and did not uphold the complaint.

Case reference 200901130

Adult Social Services Summaries

Upheld

October 2010 – Services for vulnerable adults – Powys County Council

Mr I is the father of Mr J, an adult with cerebral palsy and learning difficulties. Mr I complained that Powys County Council did not terminate the contract with the company providing care services for his son and put in place an alternative provider despite his complaints about their performance. Mr. I also complained about the lack of information he considered was forthcoming regarding the outcome of the complaint he made against the care provider and the outcome of the Protection of Vulnerable Adults (POVA) procedure instigated by the Council regarding Mr J.

The investigation found that there was delay and drift in dealing with the POVA referral and there was only limited evidence that the relevant bodies were contacted. The investigation also found that communication throughout the investigations could have been improved and that a case conference might have helped to ensure that the family was better informed. The investigation was critical of the general handling of the issues raised in the complaint, particularly the delay in dealing with the matter following the complaint in June 2008 and the lack of evidence that legal advice was sought on the contractual issues concerning the provider.

The investigation recommended compensatory payments to both Mr I and Mr J. There was a further recommendation that the Council considers adopting a clear policy regarding how it deals with complaints about care providers. There should be an audit of similar cases to establish whether case conferences have been used and, if so, whether they have been used in appropriate circumstances. Issues raised and lessons learned from the complaint should be used for staff training and the Council should ensure that its staff is fully aware of the need to engage with the relevant agencies concerning POVA investigations. The investigation recommended that the Council reflects upon the contractual and provider issues raised in the complaint and gives consideration to carrying out a review of other care providers it has a contractual relationship with. The Council agreed to implement the recommendations.

Case reference 200900324

October 2010 – Services for vulnerable adults – Caerphilly County Borough Council

Mr A complained about Caerphilly County Borough Council's response to allegations that family members had injured his mentally impaired adult son, "H". In particular, he was concerned that H was moved to a care home without a court order, about the adequacy of a protection of vulnerable adults (POVA) investigation, about the time the POVA investigation took, about the standard of communication with the family, and about the Council's response to letters from the family's solicitor and their Assembly Member.

The Ombudsman found that the delay in completing the POVA investigation was due to the time the police took to conclude their investigations and was outside the control of the Council. The Ombudsman did identify some limited failings by Council staff in the POVA process; in particular there was a failure to obtain an adequate medical assessment of H on two occasions. The Ombudsman also considered that once it was apparent that the police investigation would take some time, the Council

should have sought legal advice about the basis for H remaining in residential care.

The Ombudsman found that while communication between H's social workers and the family was generally good, it could have been improved by written updates after POVA case conferences. He also considered that the family should have been given the opportunity to meet with the POVA Coordinator.

The Ombudsman accepted that there was a limit to the information which could be given to the family and their representatives while the police investigation was ongoing; however, the Ombudsman criticised the Council for not addressing some of the points raised by the family's solicitor.

The Ombudsman partially upheld Mr A's complaints. The Ombudsman recommended that the Council should apologise to the family for the failings identified, and also made some procedural recommendations aimed at improving the Council's POVA process.

Case reference 200901188

Not Upheld

December 2010 - Services for older people – Carmarthenshire County Council

Mrs A stated that the Council should not have placed a land charge on a property formerly owned by her late in-laws, Mr and Mrs B. She complained that the Council placed them in a care home that was unable to meet their needs. She said that staff members at this home neglected and financially abused Mr and Mrs B. She alleged that the Council "ignored" the family's concerns about Mr and Mrs B's care home placement. She complained that Mr and Mrs B's social worker would not find a suitable placement for them. She stated that the family was not involved in the assessments completed in respect of Mr and Mrs B. She told us that the Council did not invite her to attend Mr and Mrs B's care plan meetings. She complained that the Council did not tell her when incidents concerning Mr and Mrs B occurred. She suggested that the financial assessment, which determined that Mr and Mrs B were able to pay for their care home placement, was flawed. She said that the Council's valuation of Mr and Mrs B's property was wrong.

The Ombudsman did not uphold those aspects of Mrs A's complaint which concerned the Council's management of Mr and Mrs B's care, its response to the family's concerns about their placement and the land charge. He did not make any findings in respect of the financial assessment and property valuation parts of Mrs A's complaint. He considered that it would be appropriate for Mrs A to pursue these issues legally.

Case reference 200801933

Benefit Administration Summaries

Not Upheld

November 2010 – Entitlement calculation – Conwy County Borough Council

Mr A complained about the Council's decision to treat a bank loan as savings for the purpose of his Housing and Council Tax Benefit claim. The Council provided the Ombudsman with a detailed chronology and the supporting documentation in respect of Mr A's benefit claim from which it was clear that he had been properly advised of his right to appeal to the Tribunal Service if he disagreed with the Council's decision. The Council had also provided a reasonable written explanation of the decision when asked by Mr A.

The Ombudsman concluded that there was no evidence of maladministration by the Council and did not uphold the complaint.

Case reference 200900761

Roads and Transport Summaries

Upheld

November 2010 – Revocation of planning permission – Monmouthshire County Council

Miss K and Mrs K complained about the Council's decision to revoke its previous permission for a dropped kerb outside a property they owned. The complainants had complained to the Council through its corporate complaints process but remained dissatisfied. The Ombudsman's investigation identified certain shortcomings in the way that the Council considered such applications and the Council in its decision letter had referred to a Policy that did not exist at that time.

The Ombudsman concurred with the recommendations set out in the Council's investigation report into the complaint regarding changes to the way it dealt with such applications and to urgently draft a Policy and procedure to ensure that all future applications for dropped kerbs are dealt with consistently. The Council also agreed to review its correspondence and approval letters regarding such matters to ensure compliance with the new Policy and procedure, to apologise to the complainants for the shortcomings identified and, to reconsider its previous decision to revoke permission having regard to the original assessment. The Council further agreed to pay the complainants reasonable and agreed legal costs directly associated with its flawed decision and to make a nominal time and trouble payment for them pursuing the complaint. The Council also reissued the previously revoked permission to the complainants for the dropped kerb.

Case reference 200901226

Children's Social Services Summaries

Upheld

November 2010 – Special educational needs – Bridgend County Borough Council

Mr Z complained about Bridgend County Borough Council concerning the Council's actions in relation to his son B. B, who did not live with Mr Z, moved back to Wales at age 15. Mr Z said that the Council had failed B in its provision of education for him and in the input offered by social services. He said that the Council had not provided a statement of special educational needs for B as he had requested. He added that it also failed to provide enough educational opportunity for him as mainstream school was not suitable for B. Mr Z stated that social services did not do enough to support B, who had major drug, offending and behaviour problems and had not administered formal assessments properly. Mr Z also criticised the Council's communications with him and its complaint handling. He said that the problems had caused much distress and led to a worse outcome for B.

The Ombudsman upheld Mr Z's complaints to a large extent whilst recognising how challenging the situation was for Council officers. Most crucially, he found that the Council had failed to respond correctly to Mr Z's request for a statement of special educational needs for B; had not carried out statutory assessments in the proper manner; had not always communicated adequately with Mr Z and failed to respond appropriately to a complaint letter. The Ombudsman made a number of recommendations including £700 redress for Mr Z, training issues and an audit of its accommodation facilities. The Council agreed to implement the recommendations.

Case reference 200901541

Not Upheld

November 2010 – Children in care – Pembrokeshire County Council

Mr C complained about the procedures adopted by Pembrokeshire County Council Social Services Department between December 2008 and February 2009 with regard to its arrangement to place his son T with his maternal grandmother, following the incarceration of Mr C and his wife. T's grandmother was resident outside of the UK. Mr C felt that the Council caused unnecessary delay in securing T's placement with his grandmother. Mr C complained that the delay was caused by the requirement of an assessment of the grandmother's suitability as a carer and enquiries with as to T's immigration status. Mr C also raised complaints concerning the Council's initial handling of his complaint.

Having taken advice from a professional advisor the Ombudsman concluded that the Council had acted appropriately in obtaining the assessment and in making enquiries with the relevant authorities. Further, it was felt that the actions of the Council had been timely. The investigation revealed some areas of service improvement for the Council in the recording of its case notes; however, it was not felt that this had caused any delay in T's placement.

Case reference 200901872

Community Facilities, Recreation and Leisure Summaries

Upheld

November 2010 – Parks, outdoor centres and facilities – Rhondda Cynon Taf County Borough Council

The complainant, Mr X, represents the 16 allotment holders of Mole Meadow ("the allotment holders"), a parcel of land privately owned by a third party. A development company submitted an application for planning permission for mineral reclamation on the land. As part of the planning consent Rhondda Cynon Taf County Borough Council ("the Council") required a performance bond ("bond") to be put in place. The purpose of the bond was to ensure that there would be money available for restoration, landscaping and the reinstatement of the allotments should the developer fail to meet the restoration conditions imposed by the planning consent. Following an agreement with the developer, the allotment holders vacated the land in order to allow mineral reclamation work to commence. However following the cessation of the mineral extraction work, the land was not restored because the development company had dissolved as a result of bankruptcy. The allotment holders expected the Council to restore the land using the money that had been placed in the bond, but that did not happen.

In November and December 1999 the Council granted permission for planning applications PP3 and PP2 respectively, which amended the original planning permission, PP1. It is clear from the Director of Planning's report that the Council had intended to request that a revised section 106 agreement and bond be attached to planning permissions PP2 and PP3, however the Council failed to do so. The effect of that failure was that there was no bond to enforce and no money available to restore the land and allotments as agreed.

The Ombudsman upheld the complaint. However it was noted that the Council had recognised its failings in this matter and apologised to the allotment holders. The Council has also has agreed to implement training on performance bonds and Section 106 agreements.

Case reference 200802476

Agriculture and Fisheries Summaries

Upheld

December 2010 - Allocation of fishing of licences – Environment Agency (Wales)

Mr T complained about the way that the Environment Agency ("the Agency") allocated licences for cockle fishing in the Dee Estuary. The Agency operated a Licence Allocation Procedure ("the Procedure") which ranked applicants according to their previous experience of fishing for cockles commercially in the Dee Estuary. Mr T believed that the Agency's errors in dealing with his application and incorrectly ranking other applicants too highly had resulted in him not being allocated a licence, which can be of a substantial financial value. Mr T complained that he had been denied an appeal by the Agency and this had denied him an opportunity to state his case. Mr T said that he had been one of only a few fishermen to have submitted catch returns for the years which he had fished for cockles in the Dee, as required by a byelaw. He complained that licences had been granted to applicants who had not submitted catch returns, and who had therefore breached the byelaw.

There was evidence of maladministration on the part of the Agency in the way that it had initially dealt with Mr T's application and right of appeal. The Agency had acknowledged those errors and apologised for them appropriately.

There was evidence that the Agency had failed to adequately follow its procedure with respect to the recording of reasons for decisions taken. Because of the resulting lack of clarity in the decision-making process, the Ombudsman could not be confident that the Agency had implemented the procedure properly or that Mr T's application had not been disadvantaged as a result. This was an injustice which arose from maladministration.

The Ombudsman recommended that the Agency apologise and make a payment of £500 to Mr T in recognition of the injustice that he had suffered through not being confident that the procedure had been implemented properly and that his application had therefore been dealt with fairly in relation to the other applicants. The Ombudsman also recommended that the Agency should undertake quality audits of its record-keeping and decisions it has taken and the reasoning behind those.

Case reference 200801692

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:

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