



# The Ombudsman's CASEBOOK

Office of the Ombudsman, Ireland

Special Edition 2021

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## Learning from complaints

When my Office examines complaints, we are looking to see whether the people complaining have received a poor service, or have not received a service they were entitled to. If this is the case we aim to put things right for them. Where possible, we try to put them back into the position they would have been in had nothing gone wrong. We also aim to make sure that mistakes are not repeated. We help public services to improve through learning from mistakes and from good practice.

In some complaints, the cause of any failure is just a one off. In others, the failures were because of issues that could cause the same failure to be experienced by others. This can be because of inadequate systems, procedures or on occasions, problems with legislation. Often, we resolve matters without the need for a full investigation. This can get matters resolved for the individual, but can mean that learning is limited.

To help tackle this issue, we introduced quarterly Ombudsman Casebooks which include summaries of cases we have closed. The Casebooks are aimed at service providers. The cases are divided into categories so that public service providers in each sector can readily learn from our findings.

This is a special Casebook we have produced of complaints we received from Carlow, Kilkenny, and Wexford in recent years. It is being published as part of a series of online Outreach events for these three counties aimed at engaging with local public service providers and complainants. We had hoped to visit the counties in person but for obvious reasons, we have to carry out our Outreach in a different way.



Ombudsman Peter Tyndall

Between the 21 and 30 September, we will:

- meet with key public service providers through video or tele-conference
- host a webinar for local elected representatives and officials of public bodies
- provide an information webinar for Citizens Information Centre staff in Carlow, Kilkenny and Wexford
- raise public awareness of the role of the Ombudsman through local advertising and media.

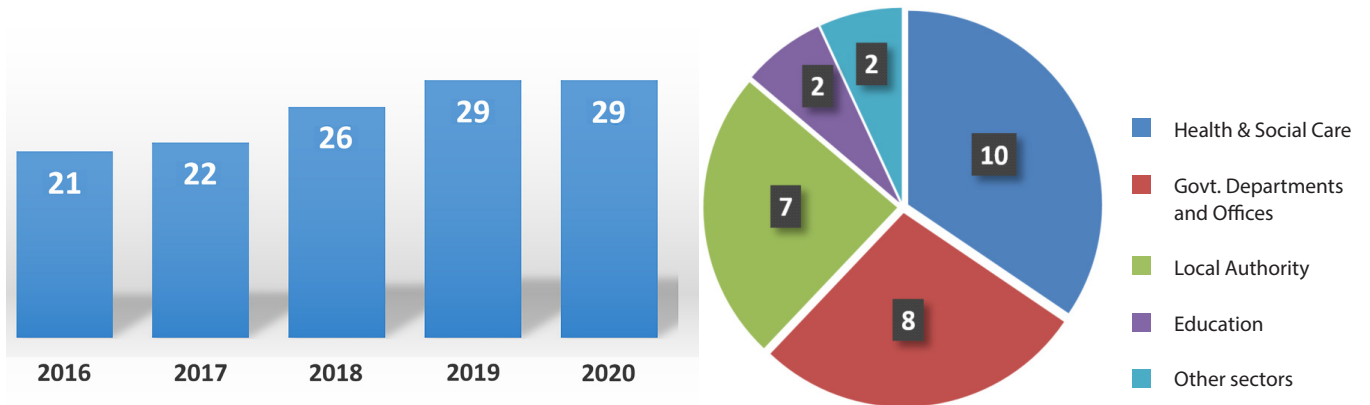
We hope that the Casebook will prove of benefit to service providers in Carlow, Kilkenny and Wexford and that it will contribute to the delivery of better public services in the future.

Peter Tyndall September 2021

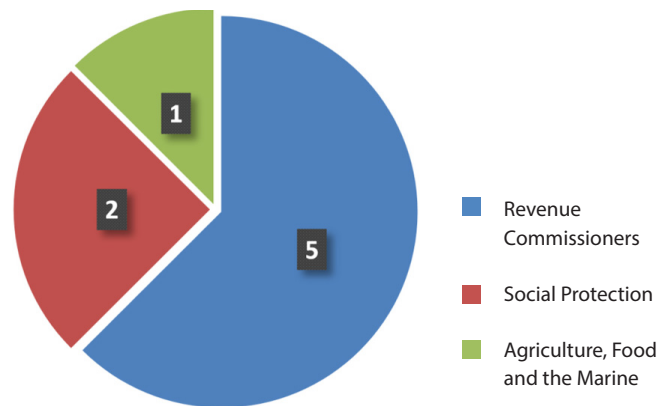
# Carlow: Complaint numbers

## Complaints received from people in Carlow

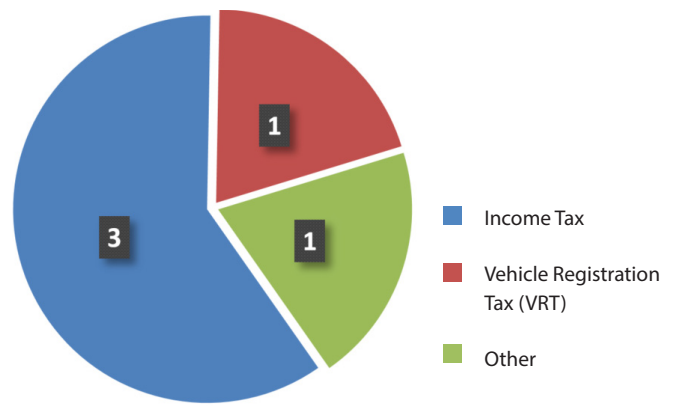
### Complaints received in last 5 years    Complaints by sector in 2020



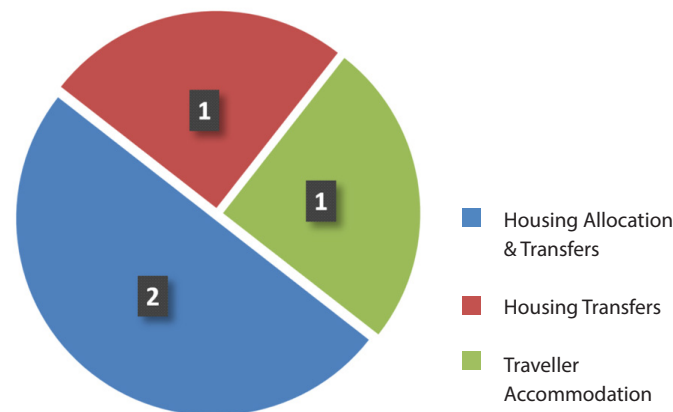
### Government Department/Office



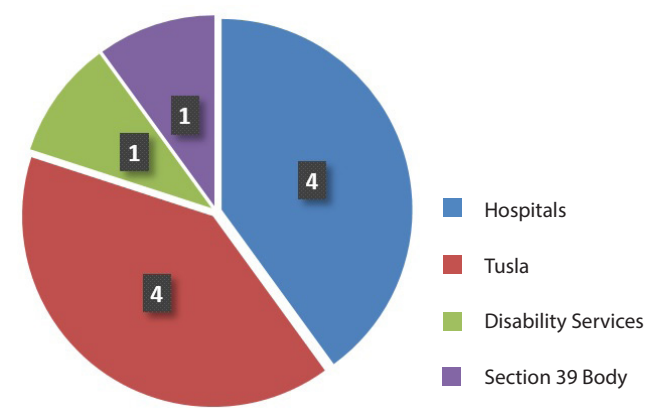
### Revenue Commissioners



### Carlow County Council



### Health and Social Care

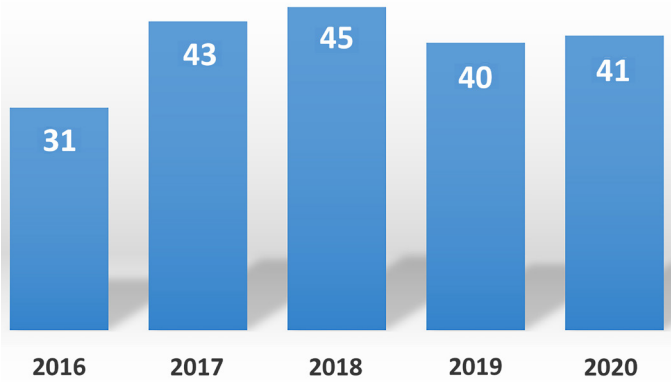


\* 3 complaints from people in Carlow were about other local authorities

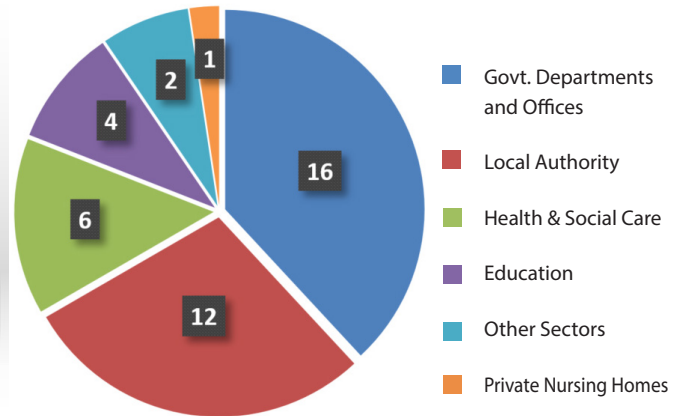
# Kilkenny: Complaint numbers

## Complaints received from people in Kilkenny

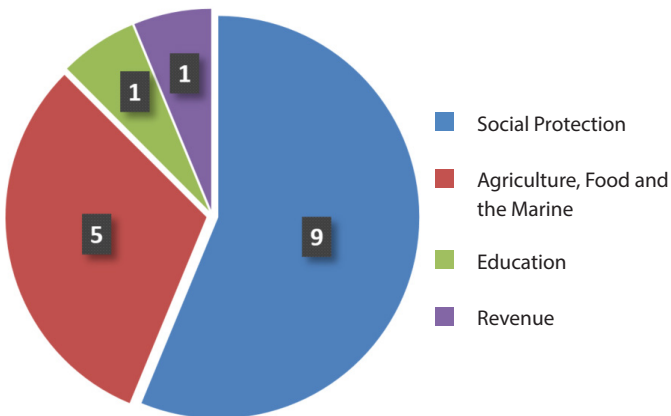
Complaints received in last 5 years



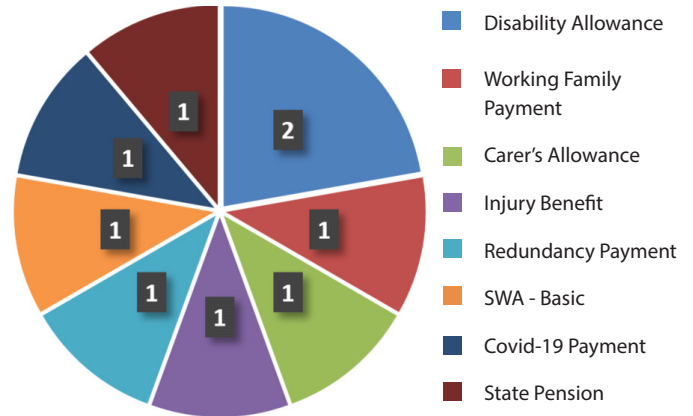
Complaints by sector in 2020



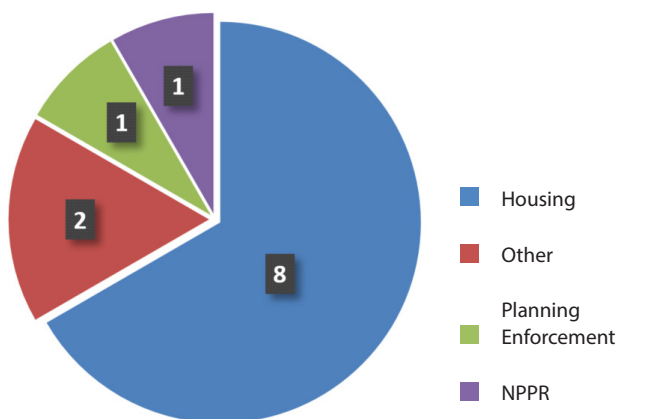
Government Department/Office



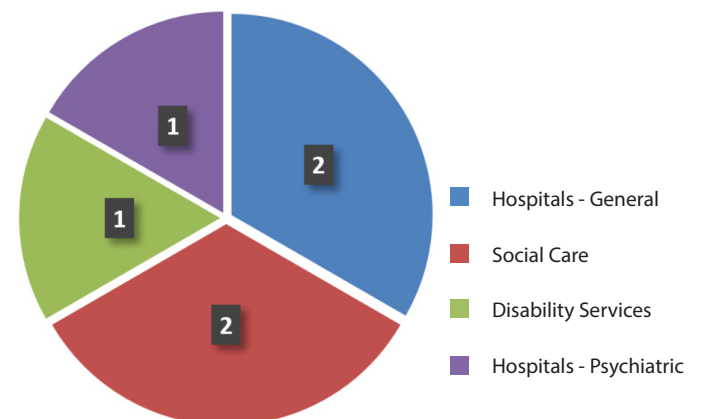
Department of Social Protection



Kilkenny County Council



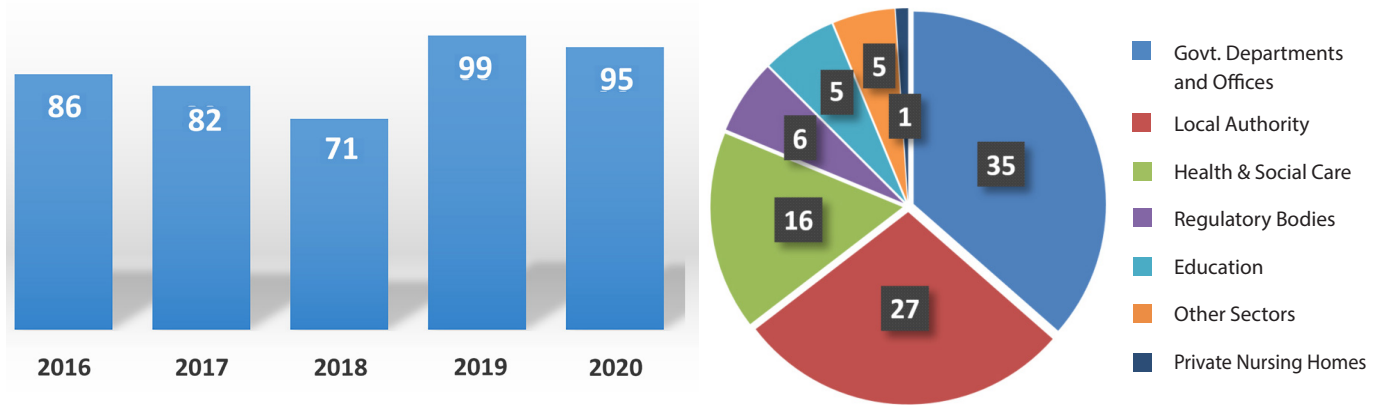
Health and Social Care



# Wexford: Complaint numbers

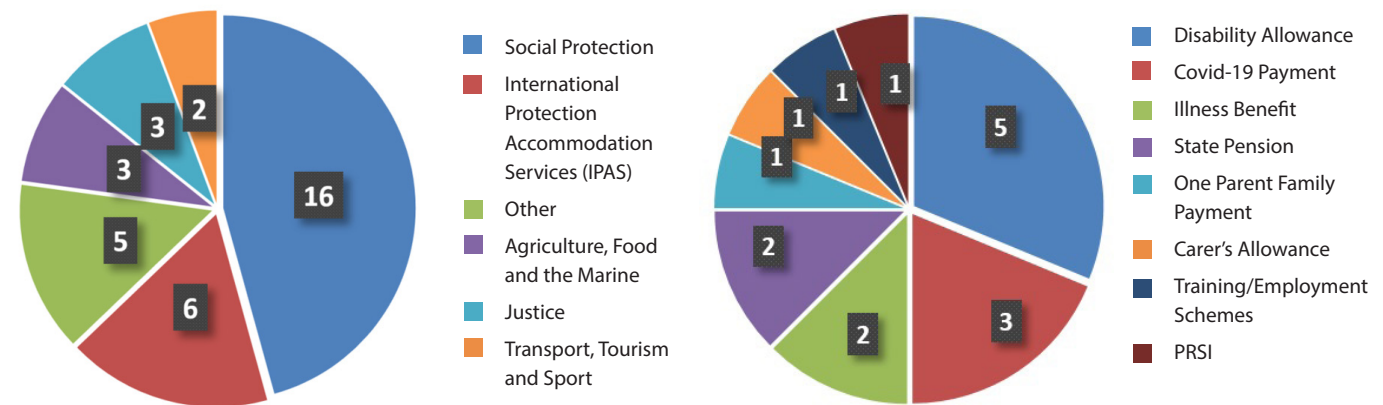
## Complaints received from people in Wexford

### Complaints received in last 5 years    Complaints by sector in 2020



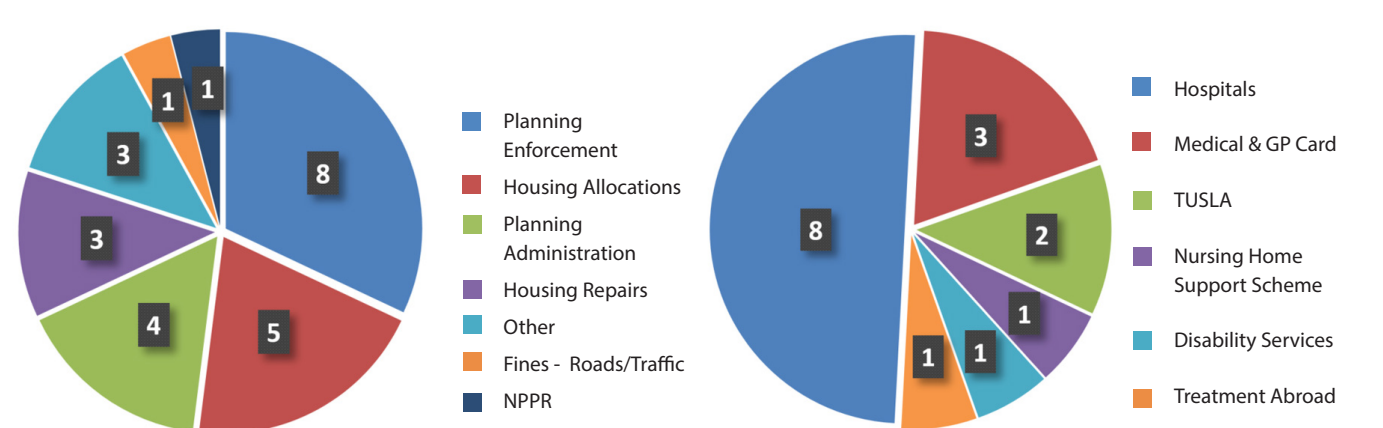
### Government Department/Office

### Department of Social Protection



### Wexford County Council

### Health and Social Care



\* 2 complaints from people in Wexford were about other local authorities

# Case studies from Carlow, Kilkenny and Wexford

This is a selection of just some of the cases we received in recent years from people in Carlow, Kilkenny and Wexford, or involving public service providers in the area.

## Local Authority

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### Housing Loan - Refused

OMB-38108-T5D8V5

# *Upheld*

#### Background

A man contacted the Ombudsman as he was unhappy with a decision by Carlow County Council on his application for a home construction loan. The man had applied for a loan with the Council to build an extension onto his house. He was approved for a loan of €38,000. However, the Council subsequently said his loan was not approved.

#### Examination

The Council had sent the loan approval documentation to its solicitors, who said that there was a significant risk attached to the loan as there was a mortgage on the property and the lender would have the first legal charge on the property in the event of a loan repayment default. The Council withdrew its loan offer two months later. The man appealed the Council's decision. After seeking legal advice, the Council offered him an unsecured loan of up to €15,000, but this did not cover the cost of the build.

#### Outcome

After examining the relevant records, the Ombudsman believed that the man could comply with the conditions set out by the Council and should be approved for the loan. He asked the Council to review its decision. The Council reviewed the application and approved the full loan subject to certain terms and conditions.

## Non-Principal Private Residence Charge - Refusal of Certificate of Exemption

OMB-91703-P5K5V6

### # *Assistance Provided*

#### Background

A man applied to Wexford County Council for a Certificate of Exemption from the Non-Principal Private Residence charge (NPPR) which he required to sell his property. The man said that the property was exempt from the charge because it was his principal private residence. The Council refused the application. The Council said the main house where the man lived was exempt but that there was also a detached studio apartment on the property which was subject to the NPPR.

#### Examination

Where a local authority refuses an application for a Certificate of Exemption, the applicant has a right to appeal the decision to the District Court. When issuing its decision, the local authority must inform the applicant of this right of appeal. The Council omitted this information in its decision in this case. The Council acknowledged that the information was not included in its decision as required.

#### Outcome

The Council wrote to the man notifying him of his right to appeal the decision to the District Court and apologising for the omission of this information from its original decision.

The Ombudsman was satisfied that the man was made aware of his right to appeal the decision. The Ombudsman could not examine the Council's decision further because the man had a legal right to appeal the decision to a court.

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## Housing - Allocation

OMB-37544-T5D6P5

### # *Not Upheld*

#### Background

A woman from Carlow complained to the Ombudsman over what she saw as an undue delay in providing her with a home. She had been on Carlow County Council's waiting list for a number of years. She said that there were special circumstances in her case as she helped care for her disabled grandson. She had been offered a house but she said it did not meet the needs of her grandson.

#### Examination

The woman had not listed her grandson on her housing application to the Council. However, the Council was aware that she helped care for her grandson, but he did not live with her and his needs were considered in the context of his mother's housing application.

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The woman was originally offered a bungalow, which the Council believed would meet her needs and the needs of her grandchild. However, it appeared the Council not made fully aware of the extent of his needs until after the offer of a bungalow was made.

## Outcome

The woman sent a number of supporting documents to the Council following her decline of the housing offer. The Council said her application would be considered in conjunction with her daughter's application. The Council reassessed the woman's needs and she was approved for a two-bedroom property. The Council also reassessed her daughter's application with a view to housing them in the same housing estate.

# Education

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## State Examinations Commission - Appeal process

OMB-92658-K9M8T1

# *Not Upheld*

### Background

A young man from Wexford complained to the Ombudsman about the decision of the State Examinations Commission (SEC) to deal with his complaint about his marks through the formal exam appeals process rather than the Rectification Outside the Appeal Process.

### Examination

The man had been awarded a H2 in his Leaving Certificate German examination although he was only a few marks short of a H1 grade. He viewed his script online and noticed that the initial examiner had made a totting error on page 2 of his script. The man applied to have his exam results changed through the Rectification Outside the Appeal Process (ROAP). The ROAP applies only in specific circumstances of errors in transcribing the overall mark from the front of the answer book to the marking sheet or an error in keying the mark from the mark sheet onto the SEC examinations database.

The SEC told him that his circumstances did not meet the criteria for his appeal to be considered under ROAP because the error had been made inside rather than on the cover of his exam script. The SEC recommended that he lodge a formal appeal instead, which he did and his marks were reviewed.

The totting error was corrected. However, he was downgraded on one part of his oral exam, which meant that his overall grade remained unchanged. The man complained to the Ombudsman saying that his case should have been considered under ROAP. If the totting error had been corrected via the ROAP, then his paper would not have been subjected to further scrutiny.

### Outcome

The Ombudsman examined the provisions of the ROAP, the appeals process and the information proved to students. The information made it clear that errors within the body of exam script itself must be routed through the SEC's appeal system.

The Ombudsman was unable to examine the decision to revise the marks for his oral exam as this involved the academic judgment of the appeal examiner and the Chief Examiner, and the Ombudsman is not involved in evaluating matters of academic judgement.

The Ombudsman could not uphold the complaint as the SEC had acted in accordance with the published procedures for dealing with appeals of exam results.



## College of Further Education - Exam process

OMB-97636-V4V8N4

### # *Not Upheld*

#### Background

A woman from Kilkenny complained to the Ombudsman about a practical skills-based course at a college of further education. She had been scheduled for a 'practical skills demonstration' but as the college had closed due to COVID-19 restrictions, the woman completed her demonstration at home but failed. She wanted to be allowed to re-do her demonstration under normal 'exam conditions' in the college but was told that it was not possible.

#### Examination

The Ombudsman examined the alternative arrangements that the college had made to assess the woman's and other students' practical skills due to the college closing. The course tutor had contacted all students and had asked them to put forward 'creative' proposals as to how they might demonstrate their skills. The tutor suggested that students could video themselves carrying out the skill at home. The woman initially agreed to video herself. However, she then changed her mind and said she would submit photos as proof instead. The tutor agreed to this but asked the woman to also submit a written report on how she had carried out the task. The woman agreed and submitted two photos but no written report was submitted to the tutor by the specified deadline. The tutor refused to accept her submission because it was late and incomplete.

#### Outcome

The Ombudsman examined the college's policy about repeat examinations and assessments. The policy does not allow students, who fail a skills demonstration or practical work, to repeat them. The Ombudsman found no evidence of maladministration on the part of the college and did not uphold the complaint.

# Health

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## Hospital - Response to complaint

OMB-59000-Z1G3M9

# Upheld

### Background

The Ombudsman received a complaint from a woman whose mother died in Wexford General Hospital (WGH). The woman was unhappy with the hospital's response to her questions about her mother's care before she died. The woman had received her mother's medical records from the hospital. The woman was particularly concerned at the discovery of a needle on the floor of the room where her mother died and a blood-stained gown her mother was wearing. She also complained that the room had not been cleaned prior to her arrival at the hospital after her mother passed away.

### Examination

Following the complaint to the Ombudsman, WGH addressed all of the woman's queries. In relation to the needle on the floor, it unreservedly apologised and said that the area should have been tidied and the gown should have been changed. It explained that it is its policy to allow relatives to see the deceased as soon as possible after death. It said that the Housekeeping team does not clear the area at the time of death. The area is cleaned after the person who has died has been removed to the mortuary. Following the Ombudsman's intervention the hospital also sent a letter of apology to the woman.

Under the Ombudsman Act (as amended), the Ombudsman is unable to examine any aspects of the woman's complaint that involved the 'clinical judgment' of the hospital, for example the treatment the woman's mother received and this was explained to the woman.

### Outcome

The hospital accepted that it had failed to address the questions asked by the woman initially. It apologised to the woman in writing and offered to meet her in person after the pandemic to discuss all the issues she had raised.

## Hospital - Care and treatment

OMB-66938-J5M7M1

### # *Partially Upheld*

#### Background

A woman from Wexford complained to the Ombudsman after her late mother, who did not drink alcohol, was prescribed medication for alcoholism and alcohol withdrawal as part of her emergency cancer treatment. Her mother had attended the Emergency Department of the Mater Hospital with severe pains in her stomach and jaundice. While giving her medical history to the hospital, she made it clear that she did not drink alcohol. The woman had a previous history of cancer and the medical team admitted her to hospital for further tests. An ultrasound confirmed that the woman had liver cancer. Later that night, she was given two medications that are commonly prescribed for individuals who have a history of alcoholism and for the treatment of acute alcohol withdrawal. Her family later noticed that she was drowsy and confused, and they spoke to the nursing team about their concerns. A doctor came to review the woman. The doctor noted that the woman had not drunk alcohol in 10 years and stopped the two medications.

The woman's family complained to the hospital that she had been wrongly prescribed medication. A short time later, the woman died, and the family felt that they had missed precious time with her because she was so drowsy from the side effects of the medication. They were also concerned that the hospital had made an assumption that their mother consumed alcohol. The hospital acknowledged that their mother was wrongly prescribed the two medications but it was unable to identify the doctor who had written the prescription.

The prescription was initialled, but with no Irish Medical Council registration number. The woman's daughter made a complaint to the Ombudsman as she felt that the hospital should have been able to identify the doctor.

#### Examination

While the hospital had apologised to woman's family it was unable to provide an explanation as to why the medications were prescribed as it had been unable to identify the doctor who wrote the prescription. Various efforts were made to try to identify the doctor, including speaking with the doctors that were working that day, completing a medication variance report form and comparing the initials on the prescription with the hospital's signature bank. An incident form was also completed. However, these actions were taken after receipt of a formal complaint from the family, as opposed to immediately after the medication error was identified. The only action taken at that stage was to stop the medication and provide the family with a verbal apology. The Ombudsman said that the incident form should have been completed immediately, and greater efforts should have been made at that time to identify the doctor, as opposed to when the complaint was received.

#### Outcome

The hospital's CEO provided a further written apology to the family. The hospital then implemented an education programme for the multidisciplinary team in respect of the identification of prescribers and recording of the Irish Medical Council registration, which

should be on all prescriptions. The hospital is also working on developing e-prescribing. A new electronic incident reporting system is also being introduced. This will be accompanied by an educational campaign, which will highlight the importance of reporting incidents as soon as possible.

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## Hospital - Waiting list

OMB-42467-Y8W7Q1

### # *Partially Upheld*

#### Background

A woman from Wexford complained that her mother was not on a waiting list for hip replacement surgery at University Hospital Waterford (UHW). Her mother had been referred to the hospital with a suspected broken hip following a fall. The woman's mother left the hospital thinking she would be called for hip replacement surgery but over a year later, the woman discovered her mother was not on the waiting list for surgery.

#### Examination

At first, doctors thought that her mother's hip might be broken and a possible hip operation was discussed. However, it was not clear from an x-ray whether or not the hip was broken. A CT scan was then carried out which showed that her hip was not broken and that she did not need surgery. As a result, her name was not entered on the hip replacement operation waiting list at UHW. However, this was not communicated properly to the woman's mother or her family who understood that their mother would be placed on a waiting list for surgery.

#### Outcome

The hospital apologised for its failure to communicate properly with the woman's mother and her family. UHW also said it would arrange an appointment with the orthopaedic team if the woman still wanted one.

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## Hospital - Care and treatment

OMB-10308-H8Y4Q8

### # *Assistance Provided*

#### Background

A woman from Kilkenny complained about the care provided to her in St Luke's Hospital, Kilkenny. The complaint concerned the insertion of a cannula into her arm (a tube inserted into a vein to administer medication), and the subsequent antibiotic provided to her through the cannula. She believed that the cannula was not inserted correctly which resulted in her arm becoming infected.

### Examination

The hospital acknowledged that the cannula caused discomfort for the woman and it apologised for the incident. The hospital said that the Clinical Nurse Manager on the ward works with her staff to ensure that care provided to patients is improved. It has also introduced bi-monthly audits on the ward around cannulas and cannula care. The hospital said that these audits have shown a significant improvement in practice.

### Outcome

The Ombudsman was satisfied that the hospital has made improvements in the area of cannula and cannula care. He believed that the hospital has taken the complaint seriously and has taken steps to improve its processes for other patients.

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## Hospital - Response to complaint

OMB-38156-L1V0P2

### # *Partially Upheld*

#### Background

A man complained to the Ombudsman as he was unhappy with the time it took for Wexford General Hospital to report and carry out a review on his complaints about aspects of his father's treatment during his time in the hospital. He also complained that the hospital had not fully responded to his complaint about the nutrition and hydration given to his father.

#### Examination

The hospital had informed the man of its expected response time in relation to both the initial report on the man's complaint and the subsequent review. The hospital said that the man would receive an update on progress if this was not going to be met. The process took slightly longer than expected due to staff on annual leave and the busy nature of the hospital. Internal emails showed that the staff managing the complaint continuously looked for updates and sought to complete the report and review as speedily as possible. Given the circumstances, some delay was understandable but the man was never provided with updates on the progress of the review as he was promised.

In relation to the second aspect of the man's complaint, the correspondence between the hospital and the man showed that the issue did not form part of his original complaint and that is why it did not form part of the initial report. On that basis it could not form part of the review but the hospital provided information to the man on its policies in relation to nutrition/hydration as part of the review report. The medical files provided to the Ombudsman showed that the man's father was closely monitored in relation to his nutrition and hydration. Any decisions regarding treatment or care of the man's father following these observations are clinical in nature and outside of the Ombudsman's remit.

## Outcome

The hospital should have provided updates to the man when the deadlines for the report and review were not met. The Ombudsman upheld this part of the complaint. The second part of the complaint was not upheld as it did not form part of the man's original complaint and the medical notes show the man's father was closely monitored in relation to his nutrition/hydration.

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## Section 39 body - Provision of disability services

OMB-97963-T7S4S2

### # Assistance Provided

#### Background

A woman from Carlow complained to the Ombudsman about the care provided to her daughter by an organisation providing disability services on behalf of the HSE (section 39 body). Her daughter is 'non-verbal' and has severe learning difficulties. She had been availing of the organisation's services for a number of years.

The woman said that the care provided to her daughter deteriorated in the last two years, and that she had reported a number of incidents to it. The organisation told the woman that a staff member had made an allegation against a colleague about an incident of 'rough handling' during her daughter's personal care. It told her an independent investigation found that the allegation was unfounded. The woman was not satisfied with how the investigation was carried out and removed her daughter from the service.

#### Examination

The woman said that the organisation had agreed to allow her view a redacted version of the investigation report on its premises, but that her request for a copy of the findings was ignored.

The organisation explained to the Ombudsman that an appointment had been arranged with the woman to view a redacted version of the investigation report, but the woman had cancelled the appointment.

The Ombudsman examined a copy of the investigation report and found that the investigation had been completed in line with the 'Trust in Care' policy, and that the relevant procedures were followed correctly. The Ombudsman also found that the organisation had recorded, and correctly dealt with, the incidents reported by the woman in relation to her daughter's care.

#### Outcome

The organisation provided the woman with the redacted version of the investigation report and findings. The Ombudsman was satisfied that appropriate action had been taken in relation to the incidents.

## HSE/Disabled Drivers Medical Board of Appeal - Primary Medical Cert refused

OMB-96706-W6D6V5

### # *Not Upheld*

#### Background

The Ombudsman received a complaint from a woman from Wexford on behalf of her mother who had been refused a Primary Medical Certificate (PMC). A PMC is needed to be eligible for the Disabled Drivers and Disabled Passengers scheme, which provides a range of tax reliefs linked to the purchase and use of specially constructed or adapted vehicles by drivers and passengers with a disability. A PMC confirms you are “severely and permanently disabled and:

- Are completely or almost completely without the use of both legs or
- Are completely without the use of one of your legs and almost completely without the use of the other leg to the extent that you are severely restricted as regards movement in your legs or
- Are without both hands or both arms or
- Are without one or both legs or
- Are completely or almost completely without the use of both hands or arms and completely or almost completely without the use of one leg or
- Have the medical condition of “dwarfism” and serious difficulties of movement of the legs.”

Her mother appealed the refusal to the Disabled Drivers Medical Board of Appeal (DDMBA). The appeal was refused by the DDMBA on the basis that the woman did not satisfy the six medical criteria set down in legislation.

#### Examination

The Ombudsman’s role in examining complaints against the DDMBA is confined to examining the administrative decisions only of the DDMBA. He cannot examine clinical decisions made by members of the medical profession. The Board of the DDMBA is made up of members of the medical profession. In the circumstances, it was not possible for the Ombudsman to uphold the complaint.

However, a decision by the Supreme Court in June 2020 found that the medical criteria and the regulations brought in by the Minister for Finance were not in keeping with the primary legislation. Section 92 of the Finance Act 1989, as amended, enabled the Minister for Finance to make regulations providing for the repayment of excise, road tax and VAT in respect of vehicles and fuel in the case of vehicles used or driven by people who are severely and permanently disabled. The Minister for Finance brought in amending legislation to the Finance Act 2020, which came into effect on 1 January 2021. The legislation aligned the definition of ‘medical criteria’ with the definition of ‘severely and permanently disabled person’ in primary legislation.

The Ombudsman has continued to raise this issue with the Department as, in the view of the Ombudsman, these criteria are extremely narrowly focussed and prescriptive. The outcome of which is that many severely and permanently disabled applicants have no prospect of qualifying for the scheme as it is currently framed.

# Department of Social Protection

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## Carer's Allowance - Overpayment

OMB-56056-Y2H0D8

# *Upheld*

### Background

A woman from Carlow complained to the Ombudsman after she was told by the Department of Social Protection to repay over €15,000 it had incorrectly paid her in Carer's Allowance.

### Examination

The woman had been repaying the overpayment in instalments for a number of years when she discovered that she may have a retrospective entitlement to Disability Allowance in or around the time she was no longer entitled to receive the Carer's Allowance. However, this was not offset against the overpayment made to her. The Ombudsman examined the woman's case and the Department's file on her claims. As a result, the Ombudsman asked the Department to review the woman's entitlement to Disability Allowance.

### Outcome

Following the review, the Department agreed that the woman had a retrospective entitlement to nearly €13,000 in Disability Allowance. The Department used the money to clear the remaining overpayment of around €6,000. The Department also refunded the woman the balance due to her.

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## State Pension - Overpayment

OMB-56196-G8X6X9

# *Not Upheld*

### Background

The Ombudsman received a complaint from a man from Wexford after the Department of Social Protection said he must repay €47,000 in social welfare payments he and his wife had received over nine years. The man said that there was a misunderstanding in that his accountant linked his pension, and that of his wife, for the purposes of his annual returns to the Office of the Revenue Commissioners.

### Examination

The man had applied for an 'Increase for a Qualified Adult' (IQA) in respect of his wife when he applied for his pension. The IQA is an extra amount for an adult dependant which is paid as an increase to a personal payment. The man declared on the application form that his wife was not working, had no other income and was being supported by him. Both the man and his wife signed a form confirming that the IQA should be paid directly to his wife.

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The Department was subsequently notified by the Office of the Revenue Commissioners that the man's wife was in receipt of an income. The man had truthfully declared this to the Office of the Revenue Commissioners. The Department calculated that he had been overpaid and should repay the appropriate amount. The man and his accountant had been advised by the Department of the option to appeal the decision but an appeal was not submitted.

#### Outcome

Having examined the information supplied by the man and the Department's file, the Ombudsman was satisfied that the Department had acted correctly in seeking repayment of the social welfare payments. The Ombudsman suggested to the man that he engage with the Department to agree a suitable rate of repayment.

# Regulatory Bodies

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## Legal Services Regulatory Authority - Refusal to investigate a complaint

OMB-91503-T0Z8K0

# *Not Upheld*

### Background

A man from Wexford complained to the Ombudsman about the Legal Services Regulatory Authority (LSRA) when it refused to admit his complaint for examination as it was too late.

### Examination

Complaints about most providers of public services, such the LSRA, are within the Ombudsman's jurisdiction. However, most of the decisions that the LSRA can take are appealable to the High Court. These decisions are outside the Ombudsman's remit as a result of section 5(1)(a)(ii) of the Ombudsman Act which provides that the Ombudsman, "shall not investigate any action where the person affected by that action has a statutory right of appeal to a court". However, the Ombudsman has jurisdiction over the decision by the LSRA that a complaint is 'inadmissible'.

Section 58(7) of the Legal Services Regulation Act 2015 sets out a number of grounds on which a complaint can be determined to be inadmissible. There is no appeal to a court of this decision and therefore they are within the Ombudsman's remit:

"The Authority shall determine a complaint under section 51 (1) to be inadmissible where it is satisfied that the complaint was made more than 3 years after the later of the following:

(a) the date on which the legal services concerned were provided or the bill of costs concerned was issued; or

(b) the date on which the client first became aware, or ought reasonably to have become aware, that it would be reasonable to consider that paragraph (a) or (b) of section 51 (1) applied in respect of the legal practitioner concerned."

The Ombudsman noted that the legal services that the man was complaining about were provided in 2015. A complaint was not made to the LSRA until 2019. Therefore, the LSRA determined that the complaint was inadmissible.

### Outcome

Having examined the facts of the case and the documentation involved, the Ombudsman found that the LSRA acted in accordance with its legislation.

## Property Registration Authority - Title issues

OMB-96168-Y7S3W8

### # *Assistance Provided*

#### Background

A man from Wexford complained to the Ombudsman about the Property Registration Authority (PRA) and the manner in which a field was removed from a map of his land. He complained that it was removed without 'due process' or sufficient supporting documentation.

#### Examination

The man had received written notification of the intention to amend the registration of the property. The PRA said that it had contacted the man after an error had previously occurred when transferring the boundaries from the PRA's hard copy maps to the digital map. It enclosed extracts from its digital maps showing the proposed location and boundaries of the man's property, and had given him 21 days to respond.

The man's solicitor wrote to the PRA on his behalf, asking it to provide evidence to enable him to consider the matter further. The PRA replied to his solicitor enclosing the original Land Commission map that registered the property on the Folio. In relation to supporting documentation, the Ombudsman asked the PRA to provide 'Map History' layers of the Folio, (that is, maps that existed over the past four to five decades) to the man. The PRA said that a copy of the original map lodged for registration by the Land Commission in 1949 was included in the Registry Amendment as well as copies of the digital map before and after the amendment was made. Prior to digitisation, mapping relating to the property was held on hard copy map sheets, which had been archived. The Ombudsman asked the PRA to follow up with the mapping department regarding accessing these maps. The PRA agreed to provide access to the hard copy map sheets, which had been archived.

#### Outcome

Having considered the correspondence between the man and the PRA, and examined the relevant files, the Ombudsman was satisfied that the PRA had followed the appropriate process in notifying the man and had given him an opportunity to respond. It had also provided the man with the documentation he needed.





# An explanation of the Ombudsman's Case Closure Categories

## 1. Upheld:

The following describe some of the scenarios where the Ombudsman upholds a complaint:

- It has been accepted by the public body that maladministration has occurred which has adversely affected the complainant.
- The complainant is found to have a genuine grievance and the body agrees to resolve/rectify the matter.
- The body departs from the original position some form of redress is offered

## 2. Partially Upheld includes:

- The complaint is not fully upheld, but the complainant has benefitted by contacting the Ombudsman.
- The complainant has a number of grievances but only some of them are resolved.
- The complainant is seeking a specific remedy but the Ombudsman decides on a lesser remedy.
- The complainant may have come to the Ombudsman with a complaint about a particular entitlement but, on examination, it is found that a different entitlement is more relevant and the complainant receives the different entitlement.

## 3. Assistance Provided includes:

- The complainant has benefitted from contacting the Office although their complaint has not been Upheld or Partially Upheld. A benefit to a complainant might take the form of:
  - The provision of a full explanation where one was not previously given.
  - The provision of relevant information, or the re-opening of a line of communication to the body complained about.

- While the complaint was not Upheld or Partially Upheld, the public body has adopted a flexible approach and has granted a concession to the complainant which has improved his/her position or resolved the complaint fully.

## 4. Not Upheld includes: The actions of the public body did not amount to maladministration. In other words, the actions were not:

- (i) taken without proper authority,
- (ii) taken on irrelevant grounds,
- (iii) the result of negligence or carelessness,
- (iv) based on erroneous or incomplete information,
- (v) improperly discriminatory,
- (vi) based on an undesirable administrative practice,
- (vii) contrary to fair or sound administration

## 5. Discontinued/Withdrawn includes: The complainant does not respond within a reasonable time to requests from the Ombudsman for relevant information.

- It has been established in the course of the examination/investigation that the complainant has not been adversely affected.
- The Ombudsman is satisfied that maladministration has occurred and that appropriate redress is being offered by the public body. The complainant refuses to accept the redress and is insisting on a level of redress which the Ombudsman considers to be unreasonable.
- The complainant initiates legal action against the public body in relation to the matter complained about.

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# About the Office of the Ombudsman

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The role of the Ombudsman is to investigate complaints from members of the public who believe that they have been unfairly treated by certain public service providers.

At present, the service providers whose actions may be investigated by the Ombudsman include:

- All Government Departments
- The Health Service Executive (HSE) (and public hospitals and health agencies providing services on behalf of the HSE)
- Local Authorities
- Publicly-funded third level education institutions and educational bodies such as the Central Applications Office (CAO) and Student Universal Support Ireland (SUSI)
- Public and private nursing homes

The Ombudsman also examines complaints about failures by public bodies to provide accessible buildings, services and information, as required under Part 3 of the Disability Act 2005.

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## Making a Complaint to the Ombudsman

Before the Ombudsman can investigate a complaint, the person affected must try to solve their problem with the service provider concerned. In some cases there may be formal local appeals systems which they will have to go through before coming to the Ombudsman - for example, the Agriculture Appeals Office, the Social Welfare Appeals Office etc. If they fail to resolve their problem and they still feel the provider concerned has not treated them fairly, they can contact the Ombudsman.

Further details on making a complaint can be found on our website

<http://www.ombudsman.ie/en/Make-a-Complaint/>

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## Contacting the Ombudsman

The Ombudsman's Office is located at 6 Earlsfort Terrace, Dublin 2.

Tel: 01 639 5600

Website: [www.ombudsman.ie](http://www.ombudsman.ie) Email: [info@ombudsman.ie](mailto:info@ombudsman.ie)

Twitter: [@OfficeOmbudsman](https://twitter.com/OfficeOmbudsman)

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## Feedback on the Casebook

We appreciate any feedback about the Ombudsman's Casebook. Please email us at [casebook@ombudsman.ie](mailto:casebook@ombudsman.ie) with any comments.

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6 Earlsfort Terrace, Dublin 2, D02 W773

**Tel:** 01 639 5600

**Website:** [www.ombudsman.ie](http://www.ombudsman.ie) **Email:** [info@ombudsman.ie](mailto:info@ombudsman.ie)

**Twitter:** [@OfficeOmbudsman](https://twitter.com/OfficeOmbudsman)