CITY AND COUNTY OF SWANSEA

NOTICE OF MEETING

You are invited to attend a Meeting of the

STANDARDS COMMITTEE

At: **Committee Room 5, Guildhall, Swansea**

On: **Friday, 7 October 2016**

Time: **9.35 am**

Membership:
Councillors: J A Hale, C E Lloyd and L G Thomas
Community Councillor: P Crayford
Co-opted Members: J Burgess, P Crayford, G Evans, J Gomes and M Williams

AGENDA

Page No.

Next Meeting: Friday, 2 December 2016 at 9.35 am

Huw Evans

Huw Evans
Head of Democratic Services
Thursday, 29 September 2016

Contact: Democratic Services – (01792 636923)

STANDARDS COMMITTEE (3)

Councillors

Labour Councillors: 2

Joe A Hale	Clive E Lloyd

Liberal Democrat Councillor: 1

L Graham Thomas	

Name	Term of Office	Name	Term of Office
Jill Burgess	19.10.2012 to 18 10.2018	Jennifer Gomes*	05.12.2008 to 04.12.2016
Philip Crayford	26.11.2015 to 25.11.2019	Margaret Williams	01.04.2015 to 31.03.2021
Gareth Evans	01.04.2015 to 31.03.2021	Vacancy	

CITY AND COUNTY OF SWANSEA

MINUTES OF THE STANDARDS COMMITTEE

HELD AT COMMITTEE ROOM 5, GUILDHALL, SWANSEA ON FRIDAY, 3 JUNE 2016 AT 9.35 AM

PRESENT: M Howells (Chair) Presided

Councillor(s)	**Councillor(s)**	**Councillor(s)**
J A Hale	C E Lloyd	L G Thomas

Co-opted Member(s)	**Co-opted Member(s)**	**Co-opted Member(s)**
J Burgess	G Evans	
P Crayford	M Williams	

Officer(s)

Huw Evans	Head of Democratic Services
Allison Lowe	Democratic Services Officer
Tracey Meredith	Deputy Head of Legal & Democratic Services / Deputy Monitoring Officer

Apologies for Absence
Co-opted Member: J Gomes

1 **DISCLOSURES OF PERSONAL AND PREJUDICIAL INTERESTS.**

In accordance with the provisions of the Code of Conduct adopted by the City & County of Swansea, no interests were declared.

2 **MINUTES.**

RESOLVED that the minutes of the Standards Committee held on 3 June 2016 be approved as a correct record.

Matters Arising:

Minute 34 – Feedback on Annual Meetings with Political Group Leaders, Chief Executive and Chairs of Committees.

The Chair reminded the Committee of the action from the previous meeting in relation to the Independent Members of the Standards Committee attending Community / Town Council meetings as an evidence gathering exercise.

RESOLVED that the Head of Democratic Services and Deputy Head of Legal & Democratic Services / Deputy Monitoring Officer draft a document outlining the remit and scope of the exercise as soon as possible.

3 **NEW MODEL CODE OF CONDUCT.**

The Deputy Head of Legal and Democratic Services / Deputy Monitoring Officer provided an update to the Committee in relation to the New Model Code of Conduct report presented to Council on 19 May 2016.

RESOLVED that the report be noted.

4 **LOCAL GOVERNMENT ETHICAL FRAMEWORK - NEW STATUTORY PROVISION.**

The Deputy Head of Legal and Democratic Services / Deputy Monitoring Officer presented a report following a technical consultation undertaken between 30 November 2015 and 10 January 2016, on the Local Government (Standards Committees, Investigations, Dispensations and Referral) (Wales) (Amendment) Regulations 2016 which came into force on 1 April 2016.

The above 2016 Regulations amended the following regulations:

- The Standards Committees (Wales) Regulations 2001;
- The Local Government Investigations (Functions of Monitoring Officers and Standards Committee) (Wales) Regulations 2001;
- Local Authorities (Grant of Dispensations) (Wales) Regulations 2001.

RESOLVED that the report be noted.

5 **PUBLIC SERVICES OMBUDSMAN FOR WALES CODE OF CONDUCT CASEBOOK (FOR INFORMATION)**

The Chair updated the Committee on the most recent publications of the Public Services Ombudsman for Wales Code of Conduct Casebooks as follows:

- Issue 6 - October 2015;
- Issue 7 - January 2016.

RESOLVED that the report and appendices be noted.

6 **PROCESS FOR APPOINTMENT OF INDEPENDENT MEMBER TO STANDARDS COMMITTEE (VERBAL).**

The Head of Democratic Services provided a verbal report on the Process for the Appointment of Independent Member to Standards Committee. He would be advertising for two positions, one to commence in approximately September and the other to commence in approximately December 2016.

A discussion ensued in relation to the previous process followed for the appointment of Independent Members and whether the process could be improved on.

The Head of Democratic Services took the opportunity to thank the Chair for his leadership during his term of office and wished him all the best for the future.

RESOLVED that the Head of Democratic Services commence the process of advertising for the Independent Members in Summer 2016.

7 **WORKPLAN 2016-2017.**

The Head of Democratic Services provided a Work Programme for 2016-2017:

Date	**Issue**
TBC	Standards Committee Annual Report
TBC	Annual meetings with Political Group Leaders and Chairs of Committees
2 December 2016	Review of Dispensation Regime
When published	PSOW Code of Conduct Casebook
TBC	Training

RESOLVED that the contents of the report be noted.

The Chair thanked his colleagues for all of their assistance during his term of office.

The meeting ended at 10.25 am

CHAIR

CITY AND COUNTY OF SWANSEA

MINUTES OF THE SPECIAL STANDARDS COMMITTEE

HELD AT ROOM 235, GUILDHALL, SWANSEA ON TUESDAY, 12 JULY 2016 AT 9.30 AM

PRESENT: M Howells (Chair) Presided

Councillor(s)	**Councillor(s)**	**Councillor(s)**
C E Lloyd	L G Thomas	
Co-opted Member(s)	**Co-opted Member(s)**	**Co-opted Member(s)**
J Burgess	G Evans	M Williams

Officer(s)

Huw Evans	Head of Democratic Services
Allison Lowe	Democratic Services Officer
Sandie Richards	Principal Lawyer

Apologies for Absence
Councillor(s): J A Hale
Independent Member(s): J Gomes
Community Councillor: P Crayford

8 **DISCLOSURES OF PERSONAL AND PREJUDICIAL INTERESTS.**

In accordance with the Code of Conduct adopted by the City & County of Swansea, no interests were declared.

9 **STANDARDS COMMITTEE ANNUAL REPORT 2015 - 2016.**

The Head of Democratic Services presented the Standards Committee Annual Report 2015-2016. The report set out the work of the Standards Committee and Community / Town Councils Standards Sub Committee from June 2015 to May 2016.

RESOLVED that the report be presented to Council on 28 July 2016 subject to minor typographical corrections and paragraph 9.1 a) be amended to include that the Standards Committee believed that the PSOW new two stage test made it very difficult for anything but the most serious of cases to progress to investigation.

The meeting ended at 9.57 am

CHAIR

Report of the Deputy Monitoring Officer

Standards Committee – 7 October 2016

PUBLIC SERVICE OMBUDSMAN FOR WALES ANNUAL REPORT AND ANNUAL LETTER 2015-2016

Purpose:	To update the Committee on Code of Conduct complaints contained within the Ombudsman Annual Report and Letter 2015-2016.
Policy Framework:	None.
Consultation:	Access to Services, Finance, Legal.
Recommendation(s):	It is recommended that:
1)	The contents of the report are noted.
Report Author:	Tracey Meredith
Finance Officer:	N/A
Legal Officer:	Tracey Meredith
Access to Services Officer:	N/A

1. Introduction

1.1 The Public Service Ombudsman for Wales has published his report for 2015-2016. Attached at **Appendix A** is the Ombudsman's letter dated 28 July 2016 and **Appendix B** is the Annual Report.

2. Annual Report

2.1 In his introduction the Ombudsman has re-emphasised his intent that his Office is devoted to issues of real concern and not trivial complaints about the Councillors Code of Conduct. He is therefore particularly concerned that the number of Code of Conduct complaints rose by 19%. This is solely attributable to Community and Town Councils, where complaints rose by 49%.

2.2 The new two stage test introduced (is there direct evidence that a breach actually took place and if so, is an investigation or referral to a Standards Committee or Adjudication Panel for Wales required in the public interest) has assisted the Ombudsman in dealing with these complaints in an effective manner.

2.3 Of the 276 Code of Conduct complaints received by the Ombudsman the top 5 subjects for complaint were:

- 41% promotion of equality and respect
- 16% integrity
- 14% accountability and openness
- 14% disclosure and registration of interests
- 7% objectivity and propriety

2.4 Of the 265 Code of Conduct complaints closed 37 were investigated (down 31%) and in only 18 was there found evidence of breach and by far the majority of those related to disclosure and registration of interest (39%).

2.5 The vast majority of complaints were closed after initial consideration i.e. no prima facie evidence of breach of the Code or breach was insufficiently serious to warrant an investigation. A few were referred back for local resolution. The reduction in cases being fully investigated is due to the introduction of the public interest test. Of the 27 cases fully investigated only 6 were referred to a Standards Committee or Adjudication Panel.

2.6 At **Appendix C** of the Ombudsman's Report, he sets out a statistical breakdown of outcomes by local authority. In relation to City and County of Swansea council there were 11 cases closed all closed after initial consideration. There were no referrals to the Standards Committee of those 112 cases closed across Wales.

2.7 In relation to Community / Town Councils the largest number of complaints closed related to Mumbles Community Council, where 5 complaints were closed after initial consideration.

3. Ombudsman Letter

3.1 The Ombudsman states in his annual letter:

"*I am only too aware that we are in the run-up to the local elections where historically there is a spike in code of conduct complaints against local authority members. I have spoken previously about vexatious complaints and I would be most disappointed to see an increase in complaints of a trivial matter over the next 12 months when my office is dealing with issues of real concern across public services in my jurisdiction."*

4. Financial Implications

4.1 There are no financial implications associated with this report.

5. Legal Implications

5.1 There are no legal implications associated with this report.

6. Equality and Engagement Implications

6.1 There are no equality implications associated with this report and therefore an equality impact assessment is not required.

Background Papers: None.

Appendices:

Appendix A	PSOW Letter
Appendix B	PSOW Annual Report

Our ref: NB/LG/MM

lucy.geen@ombudsman-wales.org.uk

matthew.aplin@ombudsman-wales.org.uk

28 July 2016

Sent by email

Dear Mr Roberts

Annual Letter 2015/16

Following the recent publication of my Annual Report I am pleased to provide you with the Annual Letter (2015/16) for **The City and County of Swansea.**

Overall my office's caseload has increased by 4% this year, but I am pleased to say that public body complaints fell by the same amount; only the second time in a decade this has happened. However, disappointingly the NHS in Wales was the only sector in my jurisdiction that saw a rise in complaints which now count for over a third of all public body complaints; a total increase of 51% in the last five years.

During 2015/16 we received 906 complaints against local authorities, down from 938 from the previous year.

In reference to outcomes there has been a large increase in the number of early resolutions and voluntary settlements achieved with local authorities with 81 cases in 2015/16 compared to 58 in 2014/15. I am committed to ensuring where possible, bodies from all sectors resolve complaints as quickly and effectively as possible and I am therefore pleased with these statistics.

My office has issued only one public interest report against a local authority during the past year – the same number as 2014/15. This related to failings around a council's failure to properly consider assess and identify the special educational needs of a primary school pupil.

Across all public bodies, after health (36%), housing is the second biggest area of complaint (13%) of our caseload, followed by Planning and Building Control (10%) and Social Services (9%).

The number of Code of Conduct complaints rose by 19% compared with 2014/15 (274 in 2015/16 against 231). It is disappointing to see this rise, although it is almost entirely attributable to community councils where there has been a 49% increase.

Last year I introduced a public interest test for code of conduct complaints and I am pleased to say this has helped my office in dealing with these complaints in an effective manner.

I am only too aware that we are in the run-up to the local elections where historically there is a spike in code of conduct complaints against local authority members. I have spoken previously about vexatious complaints and I would be most disappointed to see an increase in complaints of a trivial matter over the next 12 months when my office is dealing with issues of real concern across public services in my jurisdiction.

More generally my office is working in a number of ways to "turn the curve" of complaints against a backdrop of austerity and an ageing population.

During the past year, I introduced some staffing changes at my office, key amongst these was enhanced roles for a number of investigation staff to include 'improvement officer' duties. This places a greater emphasis on best practice, corporate cultural development, and ending cycles of poor service delivery. Whilst the new arrangements are still in their early days, I have been very pleased with the progress that has been made.

Whilst the ombudsman scheme in Wales is well respected at home and abroad, I feel strongly that we must ensure that it is future-proofed and citizen-centred.

I have been particularly pleased that the Finance Committee of the National Assembly for Wales agreed to undertake an inquiry into the powers of the Public Services Ombudsman for Wales, and that a draft Public Services Ombudsman (Wales) Bill has resulted from this. I am now keen to see the Fifth Assembly take this bill forward and introduce it as legislation as soon as is practically possible.

You will find below a factsheet giving a breakdown of complaints data relating to your local authority along with explanatory notes.

This correspondence has been copied to the Leader of the Council for consideration by the cabinet. I will also be sending a copy to your contact officer within your organisation and would again reiterate the importance of this role. Finally, a copy of all annual letters will be published on my website.

Yours sincerely

Nick Bennett

Ombudsman

Factsheet

In reference to your local authority, the number of complaints received by my office has reduced from 55 in 2014/15 to 48 in 2015/16. Housing was the biggest area of complaint with 10 cases, followed by Children's Social Services with seven. Only one complaint was taken into investigation by my office during 2015/16.

A) Comparison of complaints received by my office with average, adjusted for population distribution

In total my office received **48** complaints against the **City and Council of Swansea** during 2015-16 compared to a local authority average of **69.**

B) Comparison of complaints by subject category with LA average

Subject	2015/16 Swansea	2015/16 LA Average
Adult Social Services	2	3
Benefits Administration	1	1
Children's Social Services	7	5
Community facilities, recreation and leisure	0	1
Complaints-handling	4	2
Education	3	2
Environment and Environmental Health	2	4
Finance and Taxation	2	2
Health	0	0
Housing	10	5
Planning and building control	6	9
Roads and Transport	6	3
Agriculture and Fisheries	0	0
Independent Care Providers	0	0
Various Other	5	3
Total	**48**	**40**

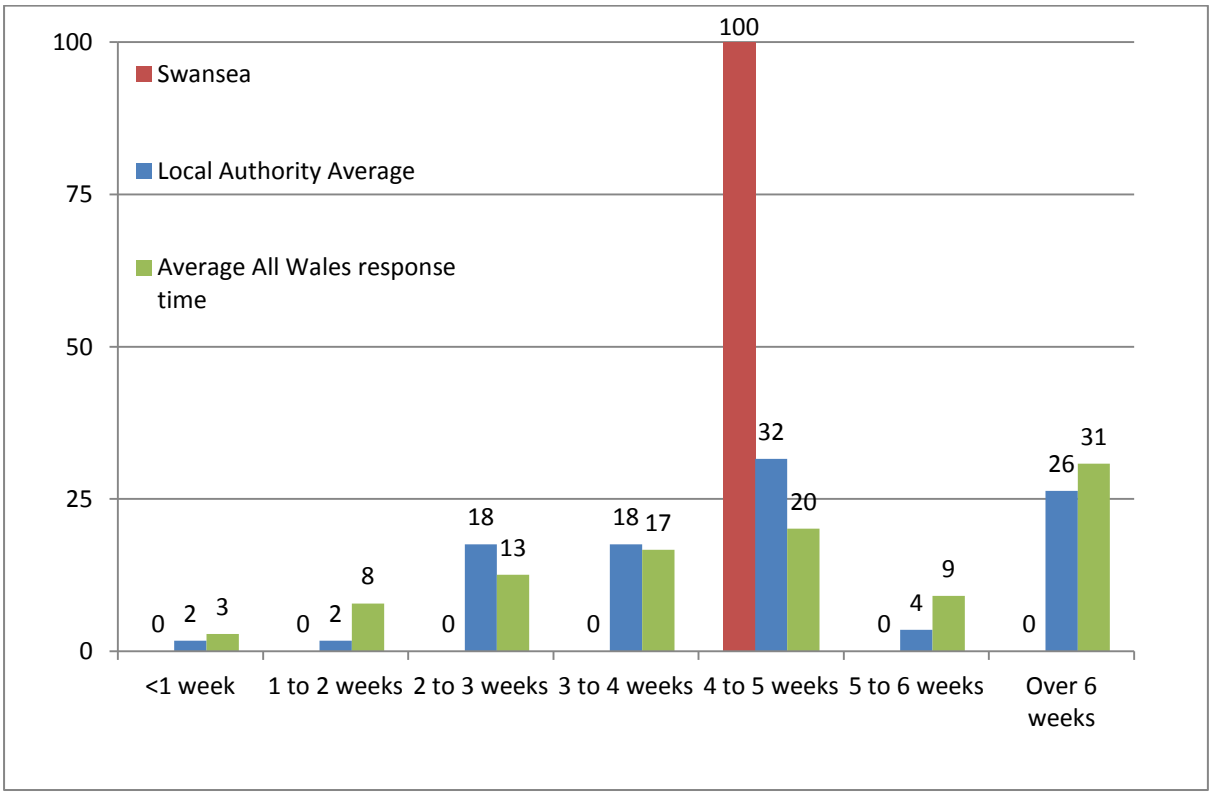
C) Complaints taken into investigation by my office

	2015/16 Swansea	2015/16 LA Average
Number of complaints taken into investigation	1	4

D) Comparison of complaint outcomes with average outcomes, adjusted for population distribution

Complaint Outcomes	2015/16 Swansea	2015/16 LA average
Out of jurisdiction	12	11
Premature	9	23
'Other' cases closed after initial consideration	19	28
Discontinued	0	1
Quick fix / Voluntary settlement	2	6
Section 16 – Upheld – in whole or in part	0	0
Other report upheld – in whole or in part	1	2
Other report – not upheld	0	1
Withdrawn	1	1

E) Comparison of times for responding to requests for information with average LA and average All Wales response times, 2015/16 (%)



F) Code of Conduct complaints

In total **11** code of conduct complaints against members of the **City and County of Swansea** were made during 2015-16. In all 11 cases it was decided not to investigate the matter.

G) Summaries

Casebook 21

No summaries

Casebook 22

201502826

Casebook 23

201500475

Casebook 24

No summaries

Appendix

Explanatory Notes

Section A compares the number of complaints against the Council which were received by my office during 2015/16, with the Local Authority average (adjusted for population distribution) during the same period.

Section B provides a breakdown of the number of complaints about the Council which were received by my office during 2015/16 with the with the Local Authority average for the same period. The figures are broken down into subject categories.

Section c provides the number of complaints against the Council which were investigated by my office during 2015/16 with the Local Authority average (adjusted for population distribution) during the same period.

Section D compares the complaint outcomes for the Council during 2015/16, with the average outcome (adjusted for population distribution) during the same period. Public Interest reports issued under section 16 of the Public Services Ombudsman (Wales) Act 2005 are recorded as 'Section 16'.

Section E compares the Council's response times during 2015/16 with the average response times for all Local Authorities and all public bodies in Wales during the same period. This graph measures the time between the date my office issued an 'investigation commencement' letter, and the date my office receives a full response to that letter from the public body.

Section F provides a breakdown of all Code of Conduct complaints received against Councillors during 2015/16. Finally, Section G contains the summaries appearing in our casebook during 2015/16.

Feedback

We welcome your feedback on the enclosed information, including suggestions for any information to be enclosed in future annual summaries. Any feedback or queries should be sent to lucy.geen@ombudsman-wales.org.uk or matthew.aplin@ombudsman-wales.org.uk

Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

ANNUAL REPORT

2015/16

10 YEARS
OF PUTTING THINGS RIGHT


10 YEARS
OF PUTTING THINGS RIGHT

The Annual Report 2015/16

of

The Public Services Ombudsman for Wales

Laid before the National Assembly for Wales
under paragraph 14 of Schedule 1
of the Public Services Ombudsman (Wales) Act 2005

Annual Report 2015/16

1. Introduction by the Ombudsman

It is with great pleasure that I present this report for the year 2015/16, which was my first full year in office, and the tenth Annual Report of the Public Services Ombudsman for Wales since the office was established on 1 April 2006.

I see my Annual Report as having two key purposes:

1. to report on the performance and work of my office over the past year
2. to draw the attention of the National Assembly and the people of Wales to the messages that emerge from the outcomes of the complaints made to me regarding any areas of concern in relation to the nation's public service delivery.

However, with the office celebrating its 10 years anniversary, it is also appropriate in this Annual Report to reflect on the journey since 1 April 2006, from being the 'new kid on the block' to becoming a mature and well respected ombudsman scheme. This report therefore also looks back on some of the key developments over the past decade.

Whilst the ombudsman scheme in Wales is well respected at home and abroad, I feel strongly that we must ensure that it is fit for purpose not only for today but also tomorrow. It is important that we understand the office's journey of the past; but we need to do so in the context of ensuring that Wales also has the modern ombudsman scheme that it deserves to the future. That is why I have been particularly pleased that the Finance Committee of the National Assembly for Wales agreed to undertake an inquiry into the powers of the Public Services Ombudsman for Wales, and that a draft Public Services Ombudsman (Wales) Bill has resulted from this. I discuss this in greater detail later in this report, but would like to take the opportunity here to record my sincere thanks to Mrs Jocelyn Davies, AM, Chair of the Finance Committee and to all the Committee members for their diligent work in this matter. I sincerely hope that the new Fifth Assembly will decide to take the Draft Bill forward, introducing it as one of its first pieces of legislation after the Assembly May 2016 election.

Whilst I am passionate about the need for the PSOW's powers to be strengthened and extended through new legislation, I have also since taking up post been considering what initiatives I can introduce to address current issues facing the office. As I reported last year, the year on year volume increase of casework was a matter of concern and I was seeking ways that would allow us to 'turn the curve'. During the past year, I introduced some staffing changes at my office, key amongst these was enhanced roles for a number of investigation staff to include 'improvement officer' duties. This places a greater emphasis on best practice, corporate cultural development, and ending cycles of poor service delivery. Whilst the new arrangements are still in their early days, I have been very pleased with the progress that has been made. To complement these changes I wanted to enhance our external communication activity and, therefore, increased the office resource accordingly. I was particularly pleased that we were able to issue a thematic report this year. This brought to public attention an area of concern emanating from the investigations of my office in relation to poor quality hospital care 'out of hours'.

At the same time that the work above was in progress, my staff and I also worked together to produce a new three year strategic plan to take us forward to 2018/19. This resulted in a new Vision, Mission, Values and Strategic Aims. I am extremely pleased with the outcome of this work and grateful to my team for the enthusiastic way that they engaged with this process. I am grateful too to the PSOW's Advisory Panel Members who also contributed to the development of the plan.

We also continued with a number of outreach activities during the year, this included giving particular attention to improving our provision for those people who are deaf or have hearing difficulties. More information about our outreach work during the year can be found in my 'annual equality report' found at Section 8 of this report.

However, by far the greatest activity of the office during the year of course was the core business of considering the complaints made to me. Whilst overall, the office caseload (which includes both enquiries and complaints) was up by 4%, interestingly and for only the second time since the creation of the office, there was a fall in the complaints received about public service providers (down 4% compared to 2014/15). Notably, the only sector that saw an increase in complaints to my office was the NHS in Wales, which was up by 4%; complaints about all other sectors fell to different degrees.

I have previously spoken about wanting to ensure that the resource of my office is devoted to issues of real concern rather than trivial complaints about the Code of Conduct. It is of particular disappointment to me therefore that complaints alleging that councillors had breached their authority's Code rose by 19%. This is solely attributable to community and

town councils, where complaints about members of these councils rose by 49%. I have been particularly pleased that the public interest test I introduced last year has helped my office in dealing with these complaints in an effective manner. I discuss this further at section 4 of this report.

Finally, I would like to thank my staff and the Advisory Panel for their support during the past year. For many members of staff it has involved direct changes to their roles and for others there have been associated effects. I am truly grateful to them for their positive attitude to the new arrangements and their continued professionalism in our common aim of ensuring administrative justice for public service users and improving public service delivery in Wales.

Nick Bennett
Ombudsman

2. My Role as the Public Services Ombudsman for Wales

As Ombudsman, I have two specific roles. The first is to consider complaints about public services providers in Wales; the second role is to consider complaints that members of local authorities have broken the Code of Conduct. I am independent of all government bodies and the service that I provide is free of charge.

Complaints about Public Service Providers

Under the PSOW Act 2005, I consider complaints about bodies which, generally, are those that provide public services where responsibility for their provision has been devolved to Wales. The types of bodies I can look into include:

- local government (both county and community councils);
- the National Health Service (including GPs and dentists);
- registered social landlords (housing associations);
- and the Welsh Government, together with its sponsored bodies.

I am also able to consider complaints about privately arranged or funded social care and palliative care services.

When considering complaints, I look to see whether people have been treated unfairly or inconsiderately, or have received a bad service through some fault on the part of the service provider. Attention will also be given to whether the service provider has acted in accordance with the law and its own policies. If a complaint is upheld I will recommend appropriate redress. The main approach taken when recommending redress is, where possible, to put the complainant (or the person who has suffered the injustice) back to the position they would have been in if the problem had not occurred. Furthermore, if from the investigation I see evidence of a systemic weakness, then recommendations will be made with the aim of reducing the likelihood of others being similarly affected in future.

A New PSOW Act?

I have outlined above the key features of my role as Ombudsman. However, during the course of the year the Finance Committee of the National Assembly for Wales conducted an inquiry into the Ombudsman's powers. Following its report on the inquiry, a Draft PSOW Bill was issued.

I was extremely pleased to see that included in the Draft PSOW Bill were the following proposals, enhancing the existing powers of the PSOW:

- the ability to undertake own initiative investigations;
- the ability to accept oral complaints;
- the ability to consider complaints about private hospitals in circumstances where a patient's pathway has involved treatment and/or care by both public and private health care providers;
- a complaints standards authority role.

Having then conducted a public consultation on the Draft Bill, in the introduction to the resultant report, the Finance Committee Chair, Mrs Jocelyn Davies, AM, noted that rather than amending the 2005 Act, it was felt that the Ombudsman's role should be governed by Welsh legislation. The aim therefore was to create one piece of bilingual legislation which would repeal the PSOW Act 2005. The report contained a number of recommendations, the first of which was:

> Recommendation 1 - The Committee recommends that a future Committee of the National Assembly for Wales should introduce the Draft Public Services Ombudsman (Wales) Bill, as soon as possible, in the Fifth Assembly.
> (Source: National Assembly for Wales Finance Committee Consideration of the consultation on the Draft Public Services Ombudsman (Wales) Bill (March 2016))

I am delighted with the outcome of the Assembly Finance Committee's work. I have commented publicly in a number of places that I think it is vital that we ensure that the PSOW's legislative basis is sound and that we can claim to be genuinely fit for the future and that legislation:

- addresses future challenges affecting service users in an ageing society where there are greater levels of physical and emotional vulnerability;
- makes a real contribution to public service improvement and reform whilst offering excellent value for money;
- ensures that citizens from more deprived backgrounds will find it easier to make a complaint;
- strengthens the citizen's voice and ensures that wherever possible processes will follow the citizen rather than the sector or the silo.

I very much hope that the Fifth Assembly takes forward the Committee's recommendation, together with the others in its report, without delay after the May 2016 election and that new Welsh legislation will soon result.

Both Finance Committee reports referred to above are available on the Assembly's website: assembly.wales

Code of Conduct Complaints

Under the provisions of Part III of the Local Government Act 2000 and also relevant Orders made by the National Assembly for Wales under that Act, I consider complaints that members of local authorities have breached their authority's Code of Conduct. I can consider complaints about the behaviour of members of:

- county and county borough councils
- community councils
- fire authorities
- national park authorities and
- police and crime panels.

All these authorities have a Code of Conduct which sets out in detail how members must follow recognised principles of behaviour in public life.

If a county councillor wishes to make a complaint about another county councillor within their own authority, then I expect them to first of all make their complaint to that authority's Monitoring Officer, as it may be possible to resolve the matter locally without my involvement.

Amendments to Legislation in Relation to the Model Code of Conduct

I very much welcomed the Welsh Government's amendments to legislation (in force from 1 April 2016). Below I draw attention to some of the key changes which impact on my role in relation to Code of Conduct complaints and are relevant to my office:

- **The Local Authorities (Model Code of Conduct) (Wales) (Amendment) Order 2016** - There is provision for a number of amendments in relation to the legislation on the Model Code of Conduct, all of which I have welcomed. Perhaps the key amongst these from my perspective is that the previous requirement placing an obligation on a local authority member to report a potential breach of the Code to me, as Public Services Ombudsman for Wales, has been omitted from the Code, but there continues to be the obligation to report such matters to the monitoring officer. However, if a matter remains unresolved following consideration by the monitoring officer, or the complaint raised is a serious one, then the complaint can then be referred on to me for consideration. This now supports the informal arrangement for resolving low level member against member complaints that this office has recently agreed with county or county borough councils. This amendment does not prevent a member from reporting a potentially serious breach of the Code to me.

- **The Local Government (Standards Committees, Investigations, Dispensations and Referral (Wales) (Amendment) Regulations 2016**

  These Regulations introduce a number of amendments in relation to:

  - The Standards Committee (Wales) Regulations 2001
  - The Local Government Investigations (Functions of Monitoring Officers and Standards Committee (Wales) Regulations 2001
  - Local Authorities (Grant of Dispensations) (Wales) Regulations 2001.

  In particular, I am pleased that:

  - provision has been made to enable a standards committee or a monitoring officer, with the prior written agreement of the Chairperson of the standards committee, to refer the report of a misconduct investigation to another authority's standards committee for determination with a view to overcoming any potential conflict of interest a standards committee may have in dealing with the complaint under consideration
  - two or more relevant authorities are now able to establish a joint standards committee
  - a member seeking to appeal the determination of a standards committee will in future first need to obtain the permission of the President, or a nominated panel member, of the Adjudication Panel.

These are all developments which this office has previously advocated and supported during past discussions with the Welsh Government and, indeed, with monitoring officers. I very much hope that these amendments will lead to both a more effective ethical standards system and a reduction in Code of Conduct complaints to my office and the associated staff resource.

3. Ten Years of the Ombudsman's Office – A retrospective of Annual Reports

Adam Peat is the first Public Services Ombudsman for Wales

2006/07

The journey begins - PSOW Act came into effect on 1 April 2006, creating a one stop shop for complaints about public service providers in Wales. It replaced the previous offices of the Commissioner for Local Administration in Wales, the Health Service Commissioner for Wales, the Welsh Administration Ombudsman, and the Social Housing Ombudsman.

2007/08

For first time health public interest investigation reports published (under previous Health Commissioner legislation making health investigation reports public was prohibited).

Focus on issuing guidance to public bodies on good administrative practice: Principles of Good Administration; and Principles for Remedy.

Peter Tyndall is now the Public Services Ombudsman for Wales

2008/09

New Strategic Plan introduced with emphasis on: being an accessible service, particularly for those in vulnerable circumstances; and streamlining PSOW complaints procedure to deal with the challenges faced due to increasing caseload.

2009/10

Complaints Advice Team created with greater emphasis on customer care, 'managing expectations' and proactive approach to Early Resolution (Quick Fix).

Guidance issued to councillors on the code of conduct for local authority members.

2010/11

Health complaints now account for quarter of all complaints to the office.

PSOW engages with Welsh Government and Assembly to propose addressing anomaly of lack of administrative justice available to people who self fund care and those who receive services from hospices.

2011/12

Work of group chaired by Ombudsman results in Welsh Government issuing Model Policy & Guidance for complaints handling for adoption by all public services providers in Wales.

Complaints Wales signposting service launched, to help people make complaints to public bodies about poor service.

NHS Redress Measure introduced and independent review stage removed; Ombudsman becomes sole independent reviewer of health complaints.

Peter Tyndall is the Public Services Ombudsman for Wales

Margaret Griffiths becomes Acting Ombudsman from December 2013

Nick Bennett is the Public Services Ombudsman for Wales from August 2014

2012/13

Ombudsman proposes reform of the PSOW Wales Act.

Ombudsman engages with Welsh Government and Assembly concerning lack of redress for people in receipt of public services delivered by private sector organisations, with particular reference to private health care.

Ombudsman reviews own governance arrangements and creates Advisory Panel.

2013/14

A time of transition begins when Acting Ombudsman takes up role.

Trend of year on year increases in complaints continue, with health complaints having increased 146% over a period of five years. Health now accounts for 36% of all complaints to the office.

Social services complaints also begin to cause concern, with a 19% increase on previous year (although from a lower base in terms of number of complaints compared to other areas of complaint).

2014/15

Ombudsman can now consider complaints about independent care providers where care is self funded, as well as hospices and domiciliary care.

Social Services Complaints Procedure (Wales) Regulations 2014 removes independent review stage; Ombudsman becomes sole independent reviewer of complaints about social services.

Assembly Finance Committee agrees to undertake a review into powers of the Ombudsman.

Ombudsman instigates innovation project to seek efficiency gains in face of ever increasing complaints caseload. Other work undertaken to 'turn the curve', includes increased emphasis on data gathering and review of staff resources.

Nick Bennett is Public Services Ombudsman for Wales

2015/16

Assembly publishes Draft Public Services Ombudsman Wales Bill.

Staff changes take place, to include introducing 'improvement officer' role and greater emphasis on external and internal communication.

And forward to the next ten years ...

... the PSOW's powers have by now been strengthened and the Ombudsman operates to the Public Services Ombudsman (Wales) Act 2016 ????

2006 10 2016
ANNIVERSARY

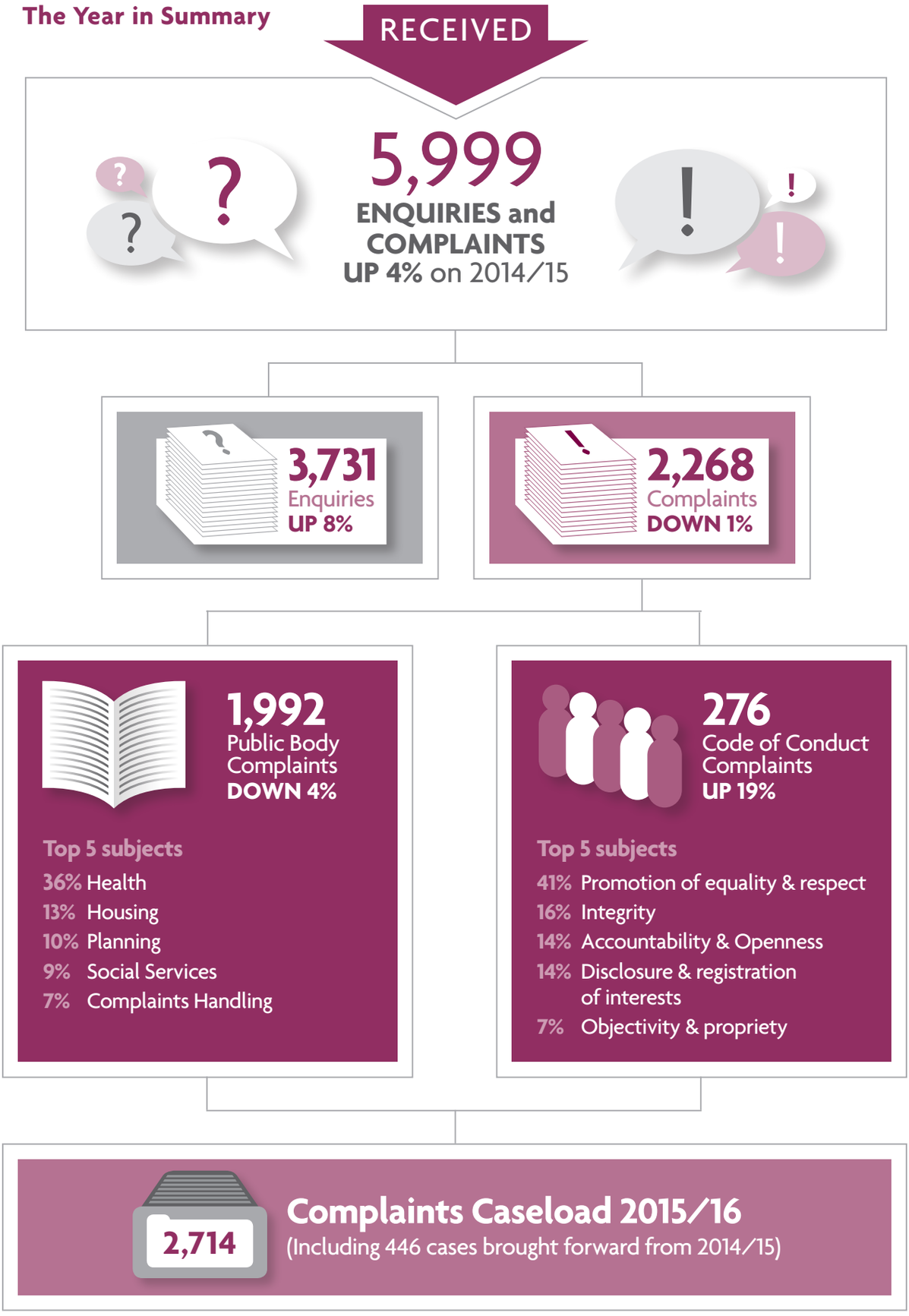
Celebrating 10 Years

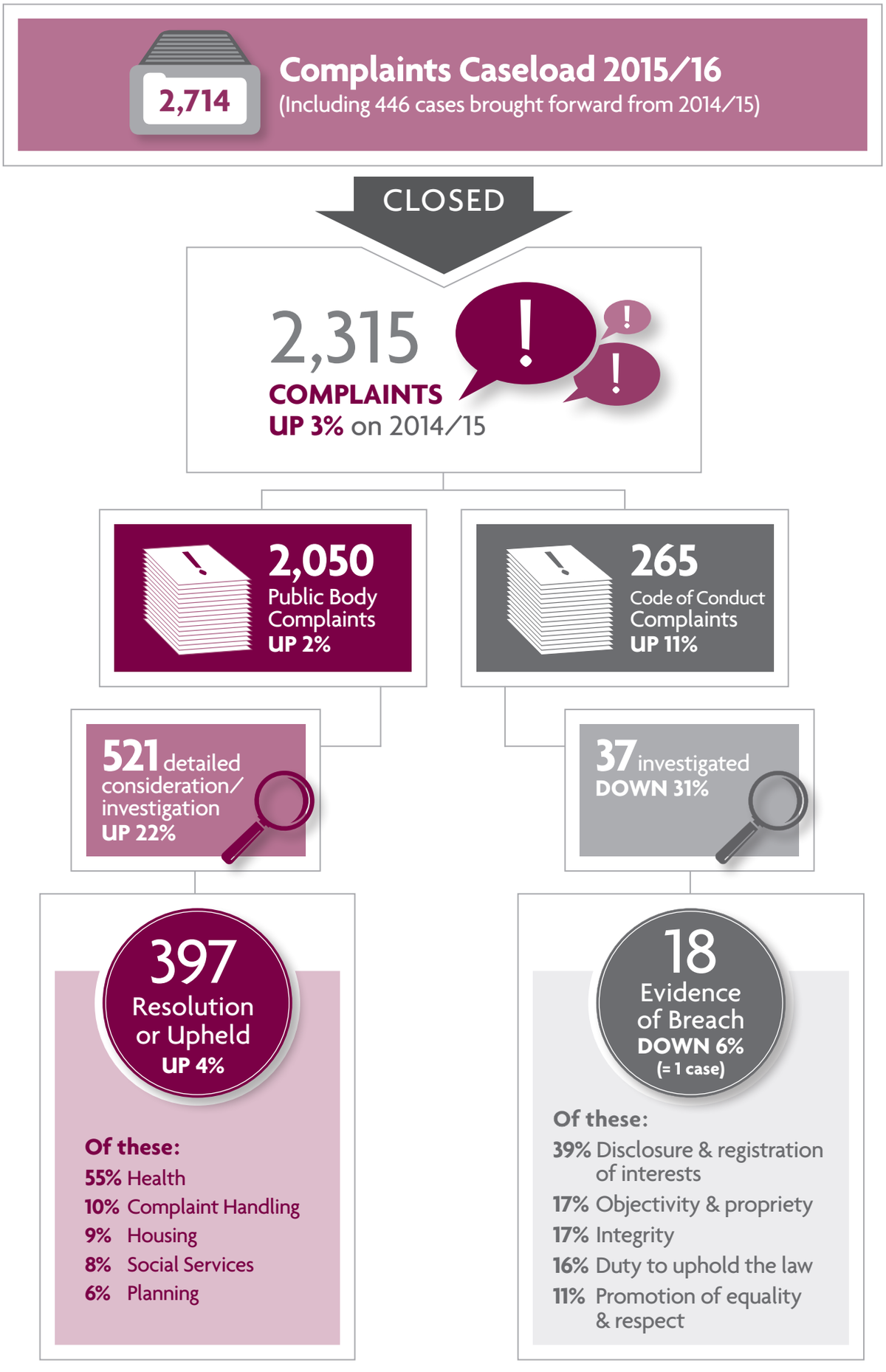
In recognising ten years of the Ombudsman's office, I was extremely grateful to Dame Rosemary Butler, the Presiding Officer, for agreeing to host an anniversary event at the Senedd Building. I was delighted that a number of Assembly Members, many public sector ombudsmen colleagues, other stakeholders and staff were able to join me to mark the occasion. It was an opportune time to reflect on the past achievements of the office as well as to look forward to the future.

Dame Rosemary Butler, Presiding Officer, welcomes Nick Bennett, Public Services Ombudsman for Wales and colleague public sector ombudsman at the Senedd

4. The Complaints Service

The Year in Summary

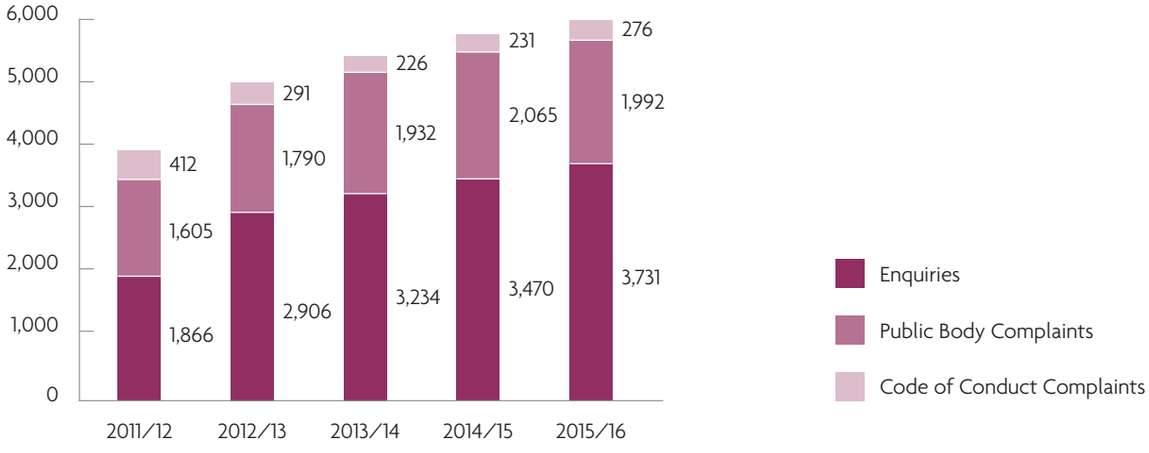



2,714
Complaints Caseload 2015/16
(Including 446 cases brought forward from 2014/15)
CLOSED
2,315
COMPLAINTS
UP 3% on 2014/15
2,050
Public Body Complaints
UP 2%
265
Code of Conduct Complaints
UP 11%
521 detailed consideration/ investigation
UP 22%
37 investigated
DOWN 31%
397
Resolution or Upheld
UP 4%
Of these:
55% Health
10% Complaint Handling
9% Housing
8% Social Services
6% Planning
18
Evidence of Breach
DOWN 6%
(= 1 case)
Of these:
39% Disclosure & registration of interests
17% Objectivity & propriety
17% Integrity
16% Duty to uphold the law
11% Promotion of equality & respect

Overall Casework

The number of enquiries and complaints (public body complaints, and complaints about the conduct of members of local authorities) totalled 5,999 during 2015/16 which is a 4% increase on the position for 2014/15. As can be seen from the chart below, comparing the position with that of five years ago, there has been a 54% increase. However, there are signs that the increases that the office has seen since the time it came into existence are beginning to plateau. I discuss the various aspects of this in greater detail below.

Total Enquiries and Complaints recieved by year



Enquiries

The office dealt with 3,731 enquiries during 2015/16, compared with 3,470 the previous year (an 8% increase). Compared with five years ago, this is a 100% increase. It is worth noting that February 2016 saw the highest ever number of enquiries made to this office.

An enquiry is a contact made by a potential complainant asking about the service provided, which does not, in the end, result in a formal complaint being made to me. At this point in our service we will advise people how to make a complaint to me or, where the matter is outside my jurisdiction, direct the enquirer to the appropriate organisation able to help them. Where appropriate, the Complaints Advice Team will also seek to resolve a problem at enquiry stage without taking the matter forward to the stage of a formal complaint.

We set ourselves the target of answering our main line reception calls within 30 seconds in 95% of cases. Yet again the Team performed impressively in this regard, answering 99% of calls within this timescale.

I am delighted that despite the continued increase in enquiries to this office we have maintained a prompt service at the frontline.

Public Body Complaints

For only the second time in the ten year history of the PSOW's office (the first being in 2008/09), there was a decrease in the complaints about public service providers compared with the previous year. We received 1,992 such complaints in 2015/16 compared with 2,065 in 2014/15, being a 4% decrease. There is no real identifiable reason for this and the number of complaints received month by month during the year was erratic, varying from being low one month, to high the next. I consider the complaints received by sector in further detail below.

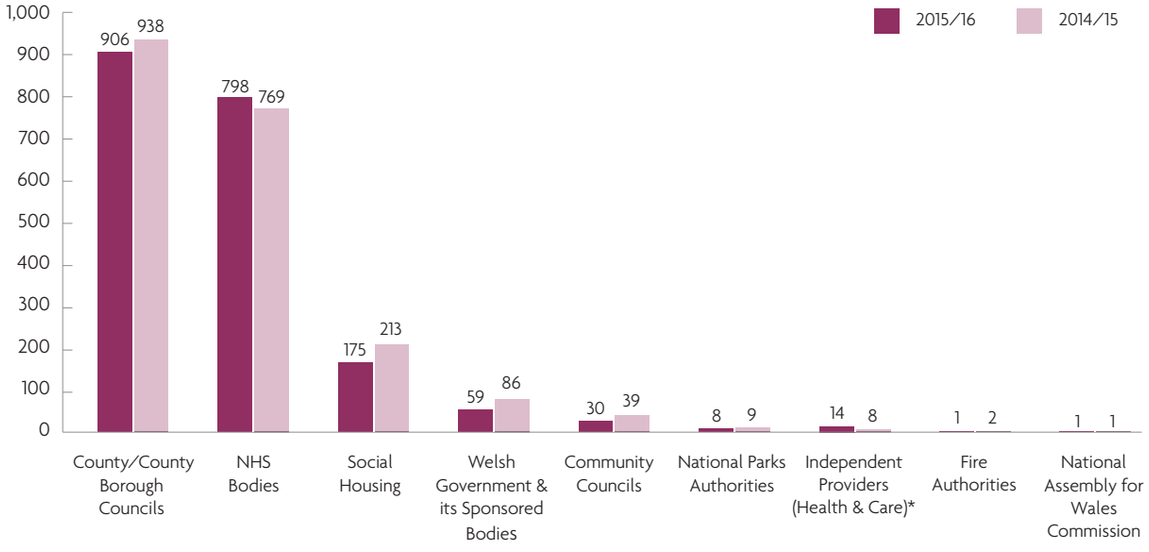
Sectoral breakdown of complaints

County councils provide the widest range of services amongst those in my jurisdiction. As usual, and as expected, it is this sector that was responsible for the most number of complaints that I received. Nevertheless, I was pleased to see a 3% decrease in the complaints about county councils over the past year, compared with 2014/15.

Indeed, there was a decrease in complaints across all sectors, with one exception. That exception was the NHS sector in Wales. This includes complaints about local health boards, NHS trusts, GPs and dentists. There was a 4% increase in complaints about health bodies compared with 2014/15 (798 compared with 769). Of the 798 health body complaints, local health boards and NHS trusts accounted for 661 of them. Within this there is a variation: there were fewer complaints about some health boards/trusts compared to last year, but a notable increase in complaints in respect of others in particular Abertawe Bro Morgannwg UHB and Betsi Cadwaladr UHB.

The chart below shows the distribution of the complaints received by sector.

Complaints by public body sector



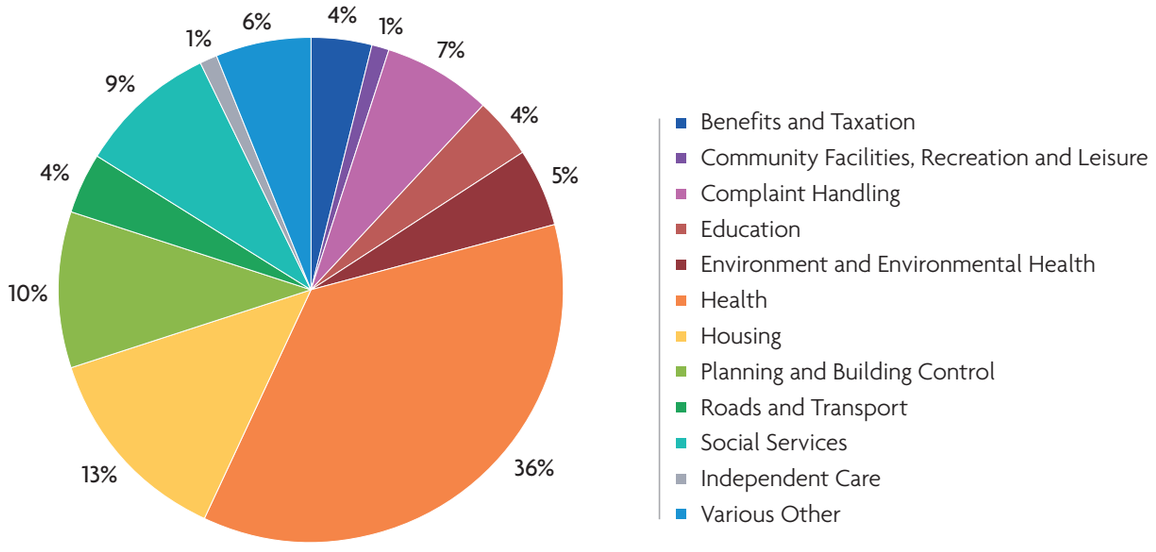
* The PSOW was able to accept complaints about independent self funded care from 1 November 2014

Complaints about public bodies by subject

Complaints to me can have many aspects to them, however, the chart below illustrates the main subject of the complaints I have received over the past year. Once again, health was the major part of the office caseload, but this year accounting for 36% of this compared with 34% in 2014/15. We have already seen that there has been an increase in complaints about NHS bodies, however, the percentage increase also arises from the fact that there have been fewer complaints about other public services. As has been the case in recent years, housing (13%) and planning (10%) are the service areas which are account for the greatest number of complaints received after health complaints.

Last year I commented on the increase being seen in relation to complaints about social services. This year there has been no significant increase in this type of complaint compared with 2014/15.

Complaints by subject 2015/16



[Note: Complaints are categorised by the main subject area of a complaint. However, complaints can also comprise other areas of dissatisfaction - for example, a 'Health' complaint may also contain a grievance about 'Complaint Handling'.]

Outcomes of complaints considered

We closed 2,050 complaints about public service providers during the past year compared with 2,015 in 2014/15, (an increase of 2%). A summary of the outcomes is set out in the table below and detailed breakdowns of the outcomes by public service provider can be found at Annex B.

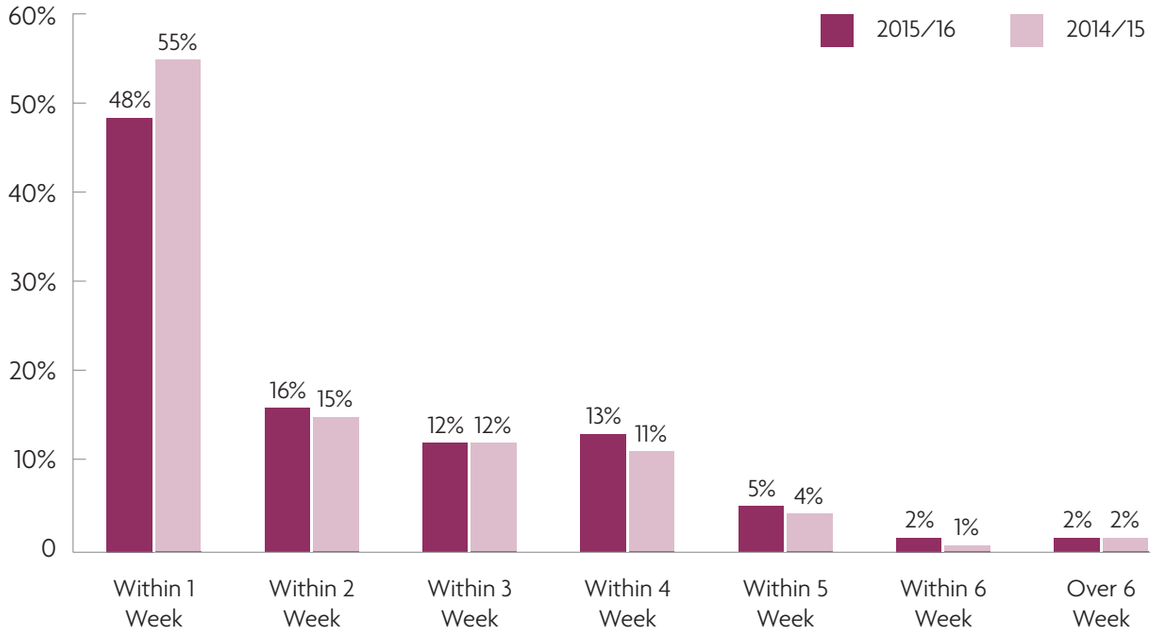
I am pleased that staff have managed to achieve this level of closure during the year, together with the fact that the number of cases on hand at the end of 2015/16 stood at 412, compared with 446 at the end of 2014/15 (which is a reduction of 8%). This is well within what I consider to be a reasonable caseload for the office to have open at any one time and this not a backlog. In addition to this, there was a 20% increase in the number of cases where we either achieved an informal resolution or took a complaint into investigation. However, there was a reduction in the number of public interest reports issued.

Complaint about a Public Body	**2015/16**	**2014/15**
Closed after initial consideration	1,488	1,564
Complaint withdrawn	41	23
Complaint settled voluntarily (includes 182 "quick fix" of cases)	227	164
Investigation discontinued	19	8
Investigation: complaint not upheld	105	71
Investigation: complaint upheld in whole or in part	163	173
Investigation: complaint upheld in whole or in part – public interest report	7	12
Total Outcomes – Public Body Complaints	**2,050**	**2,015**

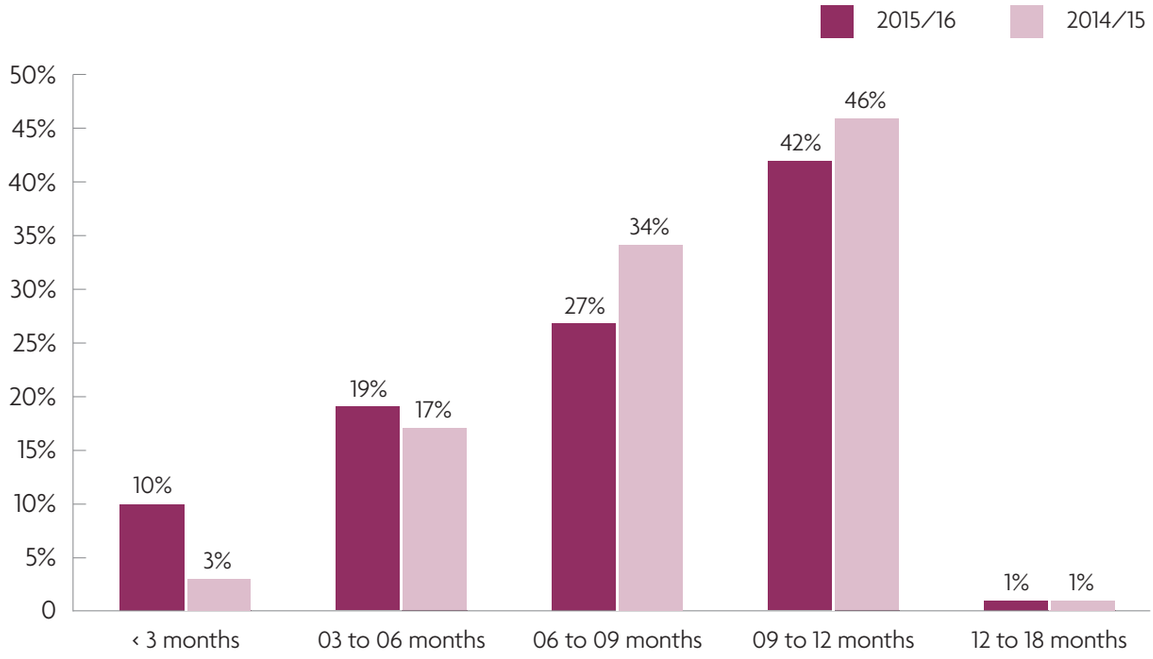
Decision times

Time taken to tell the complainant if I will take up their complaint

We set ourselves the target to tell complainants whether or not I will take up their complaint (from the date that sufficient information is received) within four weeks in 90% of cases. We just missed this target, doing so in 89% of cases (compared with 92% during 2014/15). Whilst disappointing, this is not a surprise to me in view of the continued increase in casework volume being dealt with by the Complaints Advice Team. We have been reviewing this target, and have been assessing whether a blanket four week target for all the various types of complaint consideration at this stage is now realistic and achievable in view of the level of casework. For example, at this stage, the Complaint Advice Team will endeavour to achieve, where appropriate, an early resolution to a complaint.



Similar to 2014/15, we again completed 99% of investigations within 12 months, against the 100% target we set ourselves. There were five investigations that went over 12 months. Largely these cases were complex with serious challenges which required further investigatory work. The chart below gives further details on investigation timescales.



Code of Conduct Complaints

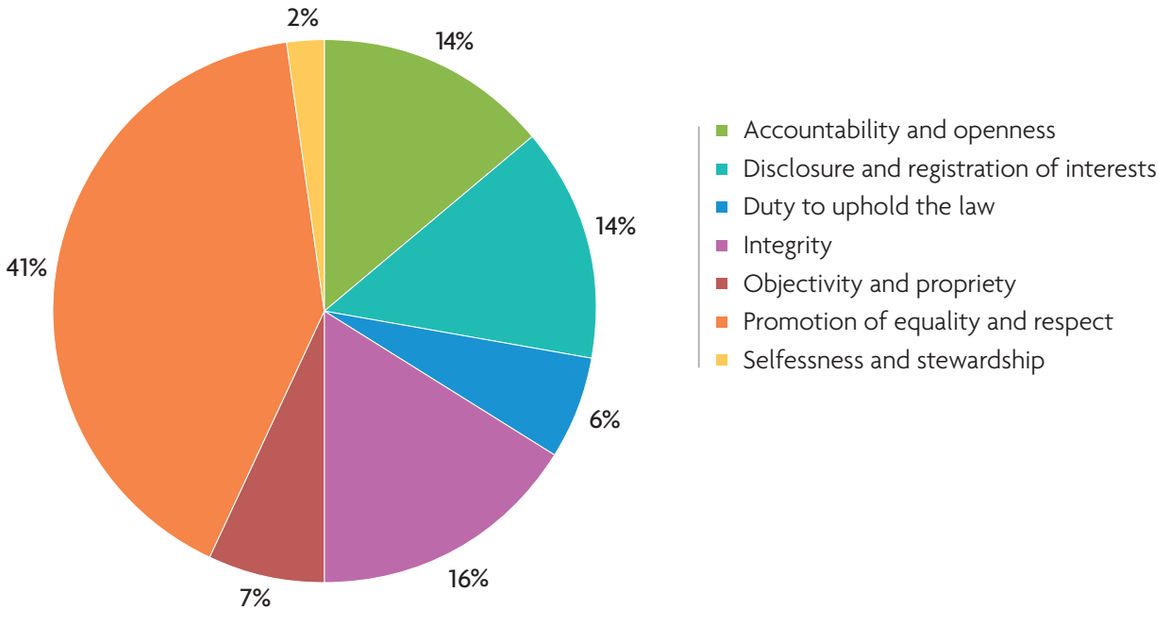
Complaints received

The number of Code of Conduct complaints rose by 19% compared with 2014/15 (274 in 2015/16 against 231). It is disappointing to see this rise, especially in relation to community councils where there has been a 49% increase.

	2015/16	2014/15
Community Council	158	106
County/County Borough Council	115	125
Fire Authority	0	0
National Park Authority	1	0
Police & Crime Panels	0	0
Total	**274**	**231**

Nature of Code of Conduct complaints

By far the majority of complaints received during 2015/16 related to matters of 'equality and respect', accounting for 41% of the complaints made to me (this was 35% in 2014/15). The next largest area of complaint related to 'integrity' at 16%, and then 'disclosure and registration of interests' and 'accountability and openness' both of which accounted for 14% of the Code of Conduct caseload.



Summary of Code of Conduct complaint outcomes

Consistent with previous years, the vast majority of these complaints (213 of them) were closed under the category 'Closed after initial consideration' (178 were closed in this way in 2014/5). This includes decisions such as:

- there was no 'prima facie' evidence of a breach of the Code
- the alleged breach was insufficiently serious to warrant an investigation (and unlikely to attract a sanction)
- the incident complained about happened before the member was elected (before they were bound by the Code), and
- with a few referred back for local resolution.

Despite the higher level of complaints received, fewer were taken into full investigation (27 in 2015/16 compared with 34 the previous year). I largely attribute this to be the result of a key change over the past year whereby I introduced a 'public interest test'. This test was developed as a result of the high number of trivial complaints received at my office, and to make clear the criteria that I will apply when considering whether a complaint should be taken into investigation or not. It also ensures that I continue to investigate serious complaints to maintain public confidence in standards of public life.

Of those 27 cases that were fully investigated, six were referred to either a standards committee or the Adjudication Panel (nine were referred in 2014/15). In such circumstances it is for these bodies to consider the evidence found, together with any defence put forward by the member concerned. It is then for them to determine whether a breach has occurred and, if so, what penalty, if any, should be imposed. Whilst at the time of writing three cases await consideration, decisions have been arrived at on the other three cases, as follows:

Hearing by:	Decision & Sanction	Nature of breach of Code
Standards Committee	Breach of Code - Councillor suspended for one month	Duty to uphold the law
Standards Committee	Breach of Code - Councillor suspended for one month	Disclosure and registration of interests
Tribunal of Adjudication Panel for Wales	Breach of Code - Councillor suspended for three months and to receive training during this time.	Disclosure and registration of interests

A breakdown of the outcomes is below:

	2015/16	2014/15
Closed after initial consideration	213	178
Complaint withdrawn	15	7
Investigation discontinued	10	20
Investigation completed: No evidence of breach	11	17
Investigation completed: No action necessary	10	8
Investigation completed: Refer to Standards Committee	3	8
Investigation completed: Refer to Adjudication Panel	3	1
Total Outcomes – Code of Conduct complaints	**265**	**239**

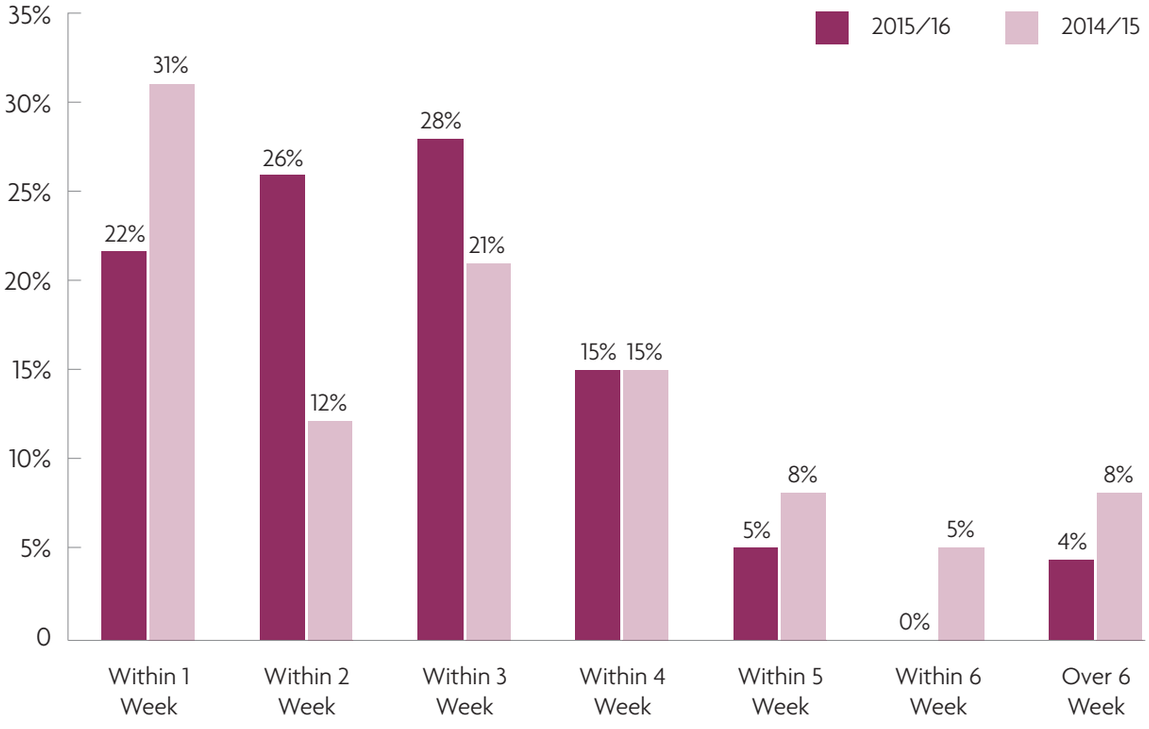
A detailed breakdown of the outcome of Code of Conduct complaints investigated, by authority, during 2015/16 is set out at Annex C.

Decision times

Time taken to tell the complainant if I will take up their complaint

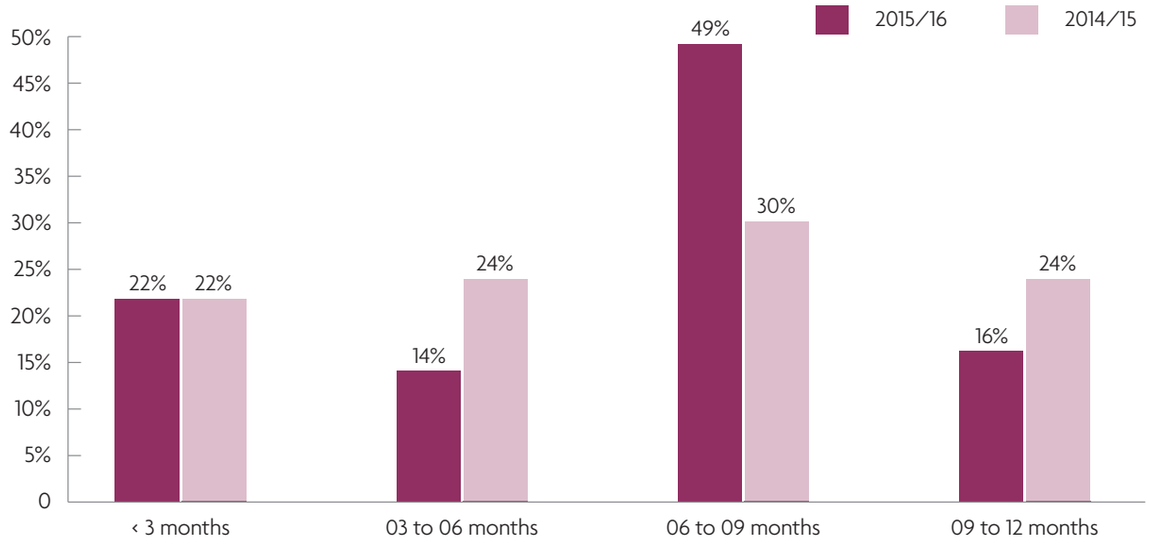
In respect of Code of Conduct complaints, 91% of complainants were informed within four weeks of whether I would take up their complaint (from the date that sufficient information is received). I'm particularly pleased that we surpassed our 90% target in this regard. Last year I reported that we achieved the four week target in 79% of cases and that I would work with my staff during this past year to ensure that we advise both the complainant and the accused member promptly as to whether I will take the matter into investigation or not. In addition to this improvement against the four week target, it is also worth noting that 96% had been informed within five weeks. My staff and I are always mindful of the fact that being the subject of a complaint can be a stressful and serious matter for the member being complained about.

Further details on these decision timescales are shown below.



Decision times for concluding Code of Conduct investigations

Comparing performance against 2014/15, in addition to the improvement in meeting the four week target, as discussed above, I am also pleased that there was an improvement on closing investigations within twelve months. Furthermore, as the chart below shows, during the past year 85% of Code of Conduct investigations were completed within 9 months, compared with 76% in 2014/15.



5. Improving Public Services

It is important to me that not only do we put things right for users of public services when poor service has been identified, but that as a consequence of our work improvements occur in those areas of service delivery where we have identified failings. Below I describe some of the initiatives introduced this year to build on already established practices in this regard.

Improvement Officers

In particular, during the course of the year I introduced into the roles of a number of investigation staff in my office, the additional role of 'improvement officer'. Whilst the main element of their role remains the investigation of complaints, their improvement role will include stakeholder engagement with certain bodies in jurisdiction as well as subject leads for areas which continue to affect quality public services.

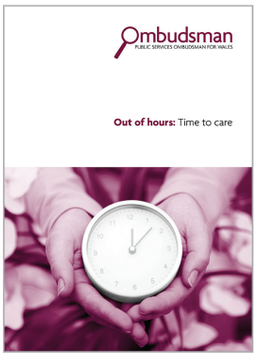
Those organisations assigned an Improvement Officer were: Abertawe Bro Morganwg UHB, Aneurin Bevan UHB, Betsi Cadwaladr UHB, Cardiff and Vale UHB, Hywel Dda UHB and Ceredigion County Council. In engaging with these bodies we hope to see ongoing improvements in complaints handling, learning and putting things right, along with the governance arrangements necessary for continuous improvement. We will regularly review our data, and the insights we gain from these arrangements, to identify any improvements. I will in due course consider whether it would be beneficial to extend this approach to other bodies.

Subject leads are now in place for:

- health (with a separate lead for clinical advice)
- housing
- local government planning services
- social services, and
- the code of conduct for local authority members.

Subject leads are specifically tasked with identifying trends from casework across the office, leading on thematic reports, and monitoring legislative and other developments affecting the subject area.

Thematic Reports



The first thematic report emerging from the new approach described above was published in March 2016. The report entitled 'Out of Hours: Time to Care' highlighted a number of cases investigated that showed inadequate standards of care given to patients in hospitals across Wales outside of 'normal' working hours.

As I can currently only look at complaints submitted to me by service users, my report called for an independent systemic review on out of hours care. In particular I identified the following areas for attention:

- inadequate consultant cover across seven days
- delays in medical review and lack of consultant review
- lack of senior supervision for junior medical staff
- failure to meet pre-existing standards of care and established guidelines.

Whilst I did not suggest that the failures in care identified by my office were typical of health service delivery in Wales's hospitals, they did not appear to be isolated incidents. An independent systemic review would confirm whether or not there were any emerging patterns or inconsistencies in quality of care in this area and, if so, allow for them to be addressed appropriately.

In addition to the above there were other activities during the year in relation to the goal of improving service delivery. In particular, I was pleased to be able to publish a joint publication with the Information Commissioner:

- **Principles of Good Administration and Good Records Management** - This was a revision of the 'Principles of Good Administration' originally issued by the Ombudsman in 2008. I was delighted to be able to work with the Information Commissioner in reviewing this document, which now includes two new Principles in relation to good records management. Following consultation with bodies within my jurisdiction, the new document was published in February 2016.

- **Enhanced Data Capture** – We have also during the year reviewed the level of data that we capture in relation to the complaints made to me, with particular focus on health complaints in the first instance. The aim is to enable us to identify trends at a more micro rather than macro level. As we only begun inputting data at this level during this year, it is too early to have been able to benefit from this yet. However, I hope that we will be able to derive useful information to act upon during 2016/17.

Furthermore, sight should not be lost of the already established vehicles used to highlight areas for service delivery improvements by bodies in jurisdiction. These included:

- **Public interest reports** – Seven such reports were issued during 2015/16 and summaries of these investigation reports together with findings and outcomes are set out at Annex A. The full reports are available on my website at www.ombudsman-wales.org.uk.

- **The Ombudsman's Casebook** – These continued to be published quarterly. Four main areas highlighted for service improvement in the publications issued during the year were:
  - services for vulnerable citizens
  - reducing the distress of dying - why improvements are needed to end of life care
  - GP services
  - special needs education.

- **The Code of Conduct Casebook** – At the request of its readership, we began issuing these quarterly during 2015/16 rather than on a six monthly basis, which was our previous practice. An annual commentary by me is to appear in the April editions of the Casebook.

- **Annual letters** – These are issued to county councils and health boards and used as the basis of discussions with the Chairs and Chief Executives of individual local health boards. Local authorities are also invited to seek a meeting to discuss their particular Annual Letter if they so wish. It is intended that the Annual Letters to be issued during 2016 in respect of the operational year 2015/16 will for the first time include an improvement officer's commentary in relation to those bodies assigned an improvement officer.

6. Governance and Accountability

The Ombudsman

The Public Services Ombudsman (Wales) Act 2005 establishes the office of the Ombudsman as a 'corporation sole'. The Ombudsman is accountable to the National Assembly for Wales, both through the mechanism of the annual report, and as Accounting Officer for the public funds with which the National Assembly entrusts the Ombudsman to undertake their functions.

I appeared before an Assembly committee on a number of occasions during the past year. This included the Communities, Equality and Local Government Committee to discuss the Annual Report for 2014/15; and the Finance Committee to discuss my budget estimate submission for 2016/17. I also appeared before the Finance Committee in relation to providing evidence to its inquiry into the PSOW's powers. I welcomed the opportunity on each occasion to discuss not only the work already undertaken by my office, but also what the work of the office could look like in the future.

Advisory Panel and Audit & Risk Assurance Committee

As reported last year, although a corporation sole, I have an Advisory Panel which provides both challenge and support to me as Ombudsman. There is also an Audit & Risk Assurance Committee, a sub-committee of the Panel. Having reviewed the level of membership during the past year, I decided to strengthen its membership by one additional member. An open/public recruitment exercise was conducted. I was very pleased to appoint Mr Jonathan Morgan from a strong field of candidates. Mr Morgan served as an Assembly Member for 12 years, and is a former Chair of the National Assembly Public Accounts Committee. He joined the Panel in March 2016 and will also be a member of the PSOW's Audit & Risk Assurance Committee.

The work of both the Panel and the Committee over the past year will be reported in greater detail as part of the Governance Statement within my Annual Accounts for 2015/16.

Management Team

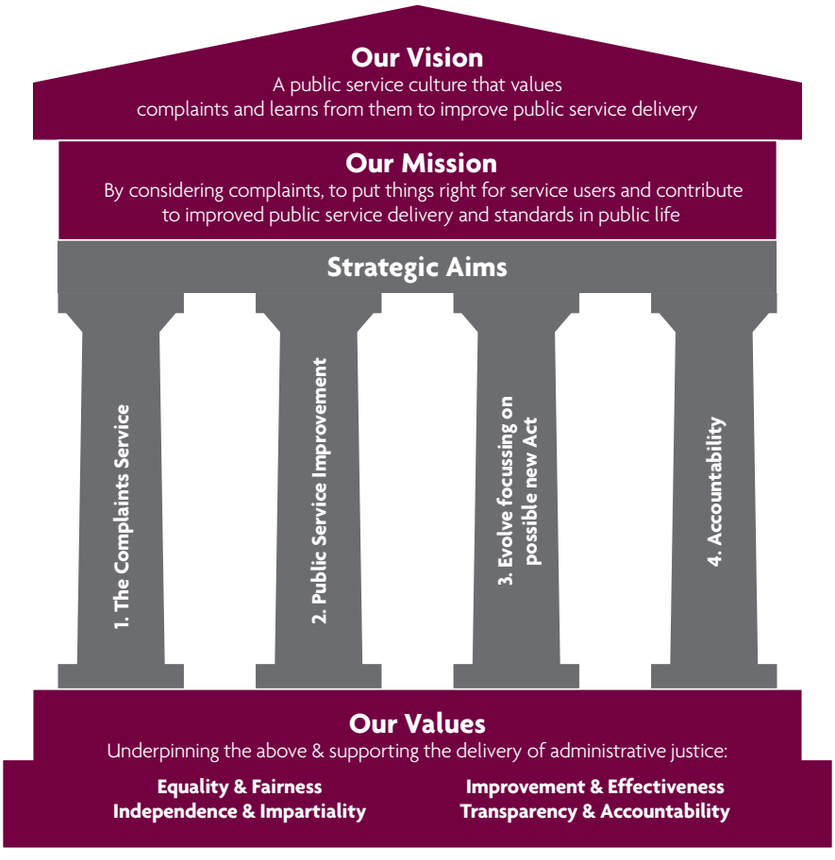
The Management Team has continued to support and advise me in relation to strategic direction as well as the operational, day to day, running the office. I am particularly grateful to them this year for ensuring a successful and seamless staffing and operational transition. The revised staffing structure can be found at page 30.

Three Year Strategic Plan

This was the final year of the existing strategy and, therefore, during the year, my staff and I developed a new three year strategic plan for the office to the operational year 2018/19. We held a number of workshops, which proved to be very productive. A separate workshop was also held for Advisory Panel Members and I was very grateful to them for their contribution. A new Vision, Mission, Values and Strategic Aims resulted from this work.

Whilst taking forward the service under the existing powers of the Ombudsman was a key focus for our discussions, I felt that it was important that we created space in our strategic planning to implement any new PSOW Act that might be created during the lifetime of the plan. However, I wish to reinforce the message in this report that in doing so I have not taken anything for granted in relation to the introduction of new legislation or what that legislation might contain.

Below is an illustrated summary of the strategic plan, the full text of the Strategic Aims can be found in the comprehensive document entitled 'Three Year Strategic Plan 2016/17 to 2018/19: Innovation, Influence, Improvement' on the website: www.ombudsman-wales.org.uk

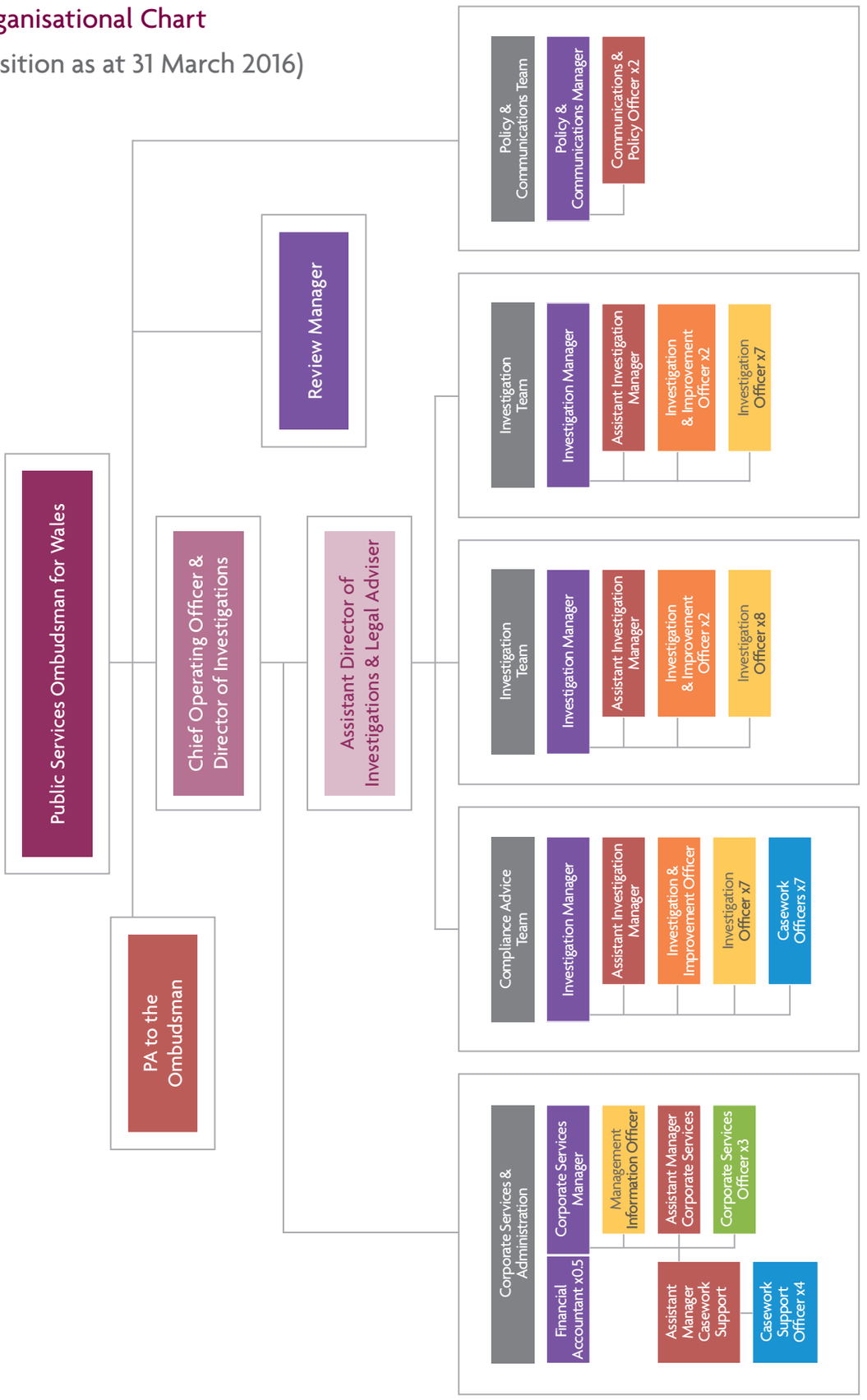


European Directive on Alternative Dispute Resolution

Last year I reported on the possible impact on the PSOW of the European Directive on Alternative Dispute Resolution and the Alternative Dispute Resolution for Consumer Disputes (Competent Authorities and Information) Regulations 2015 that the UK Government laid before Parliament on 17 March 2015. At the time of writing my report last year I was still considering whether or not it was appropriate for the PSOW to apply to be an ADR entity. For completeness, I now report here that I concluded that it was not appropriate for the PSOW to do so. Furthermore, since my decision, other UK public sector ombudsmen (and the Irish Ombudsman) have arrived at a similar conclusion.

Organisational Chart

(Position as at 31 March 2016)



7. Other Activities

Co-operation with Commissioners

I have been actively looking for opportunities to co-operate with other ombudsmen and commissioners in circumstances where this is appropriate. I have already reported on a publication I issued jointly with the Information Commissioner, and I am pleased that I can report on another two specific developments that have taken place over recent months:

- **Internal Audit Contract** – With the end of the PSOW's internal audit contract on the horizon, I was pleased that the Children's and Older People's Commissioners agreed that, with a view of achieving cost savings, it would be beneficial to procure on the basis of comprehensive internal audit tender process upon which each Commissioner's office could then draw upon individually. A successful tender process resulted to the satisfaction of both Commissioners and myself,

- **Future Generations Commissioner** – I also had very positive discussions with the new Future Generations Commissioner and was pleased to be able to agree to provide the Commissioner with a staff salaries service for her office.

In addition to the above, I have continued to meet regularly with the Commissioners in Wales to discuss issues of mutual interest.

Complainant satisfaction research

We have continued with our satisfaction survey practice in relation to customer satisfaction for our first contact service. The table below gives the outcome for 2015/16 as follows (some respondents did not answer every question; the 'no responses' have been disregarded in respect of the outcomes below):

	% of respondents answering either 'strongly agree' or 'agree'
It was easy to find out how to contact the Public Services Ombudsman for Wales	95%
The service I have received has been helpful and sensitive	88%
Staff were able to understand my complaint / The person that dealt with my query knew enough to be able to answer my questions	88%
I was given a clear explanation of what would happen to my query/complaint	89%
The service has provided what I expected of it	83%

Clearly, the above outcomes are very pleasing; not least against the background of the increased volume of work faced by the frontline service as discussed earlier in this report.

We have also been considering other ways of understanding various stakeholders' views of my service. Looking at good practice elsewhere in the ombudsman community, I have decided that we should establish a number of sounding boards in this regard. The first of these will comprise members of advice and advocacy bodies, particularly inviting those organisations who help complainants through the complaints process. I also intend forming sounding boards to gain feedback from other organisations, including members of bodies within my jurisdiction, to understand their perspective on the service provided by my office. I hope that the first of these will be in place at the end of the first quarter of 2016/17.

Communications

External:

- Media - A positive relationship with the media continued over the past year and meetings with a number of journalists, particularly broadcast journalists took place to discuss and explain matters of current concern and interest to the office. Once again a number of opportunities arose for me to give television and radio interviews. There was an excellent level of reporting on the 'Out of Hours: Time to Care' thematic report as well as on the public interest reports that I issued during the year.

- Website and Social Media – We have during the year been reviewing the PSOW website and our social media activity. As a result we further developed our social media presence by adding to the existing Twitter account by introducing a Facebook page and also creating a YouTube channel. We intend to commence work on revamping the website during 2016/17.

Internal: We have also enhanced and improved internal communication activities in the office. In particular a weekly bulletin is now being produced for staff which highlights press attention gained by the ombudsman's office, as well as articles in the press relevant to the work of the office. The bulletin is also used to share around the office briefings from various meetings that staff have attended. In addition to the bulletin a new version of the Magnifying Glass, the staff newsletter, has been introduced and this now appears in an online digital format.

The Ombudsman Community

Over the years, despite being a relatively small Ombudsman scheme compared to those of other countries, the PSOW has punched above its weight in relation to its position within the ombudsman community. PSOW officeholders have held senior offices at the OA (the British and Irish Ombudsman Association) and the International Ombudsman Institute.

I was delighted to be able to continue to carry the torch when, in May 2015, I was elected as the Vice Chair of the OA. An Ombudsman is pretty much a unique role and membership and participation within such organisations are important. This allows us to share best practice, learn from each other and indeed advance the ombudsman institution in light of external developments. Other members of my staff have also continued to participate in OA activities, including participating in a number of the OA Interest Groups.

Complaints about the PSOW service

We have over the past year also reviewed and revised our own complaints policy and procedure. That is the procedure for those people who want to complain about the service I provide. A key change is that I have decided to appoint an independent external reviewer of complaints about my service.

This review service is available to those who have complained to me about my service, but remain dissatisfied having received my response. It is not for the reviewer to 're-investigate' a complaint or review a decision taken by me (in respect of a complaint about a public service provider), but to consider the service my staff have provided bearing in mind the examples listed below. Following any review, I will then consider any recommendations or suggestions the reviewer may make.

I have taken this step with a view to taking further the developments of recent years in making the PSOW open to scrutiny and review; in this instance in respect of the handling of complaints about the PSOW service.

The policy can, for example, be used when complainants feel that we have:

- treated them unfairly or rudely; or
- failed to explain things clearly; or
- caused unreasonable delays; or
- failed to do what we have said we would; or
- failed to follow our processes correctly.

The policy for complaints about my service also accommodates the process for when someone wants to request an internal review by the PSOW of the decision on their complaint about a public service provider.

Further details about this policy is available on my website: www.ombudsman-wales.org.uk.

The table below reports on the number of complaints received during 2015/16 and their outcomes, together with a comparison of the position in 2014/15.

	2015/16	2014/15
Complaints brought forward from previous year	1	3
New complaints received	61	82
TOTAL COMPLAINTS	**62**	**85**

OUTCOMES		
Not upheld (service related issue)	20	14
Upheld in whole or in part	15	12
Related to investigation decision - referred to investigation process	18	44
Complaint withdrawn or insufficient information	9	14
Total closed during year	**62**	**84**
Ongoing and carried forward at 31 March	0	1

The nature of the complaints that were upheld/partly upheld were:

Undue delay in response / or delay in correspondence referral	4
Interview Digital Sound recording error	1
Incorrect information provided	1
Incorrect complainant title / salutation on correspondence	1
Internal records not updated in a timely manner	1
Incoming courier process error	1
Misfiling of correspondence	1
Correspondence sent in error	5
Total	**15**

The following corrective action was undertaken:

- an apology was issued to the complainant in all 15 cases
- the relevant line Manager(s) were made aware of the upheld complaints relevant to their team for future training and monitoring
- appropriate and relevant staff training was undertaken where necessary
- appropriate action in accordance with PSOW Human Resources policies was undertaken
- relevant policies / processes reviewed to minimise risk of re-occurrence.

Report on Independent Review of Complaints About the PSOW Service

Whilst the arrangement for independent external review of complaints about my services has been in place for less than a full year, a report has been prepared for the four months to 31 March 2016. Seven complaints were referred to the external reviewer, but none was accepted for review. One was premature, in two cases further advice was sought from the external reviewer and in the remaining four cases the complaint was about my decision on their complaint about a public service provider, rather than about the service provided by my staff. The independent external reviewer made two recommendations: that I provide greater clarity about the role and limits of internal complaints and review processes, and possible routes, at the beginning of the process, and that I add further details of the limitations of the independent external review service to my responses to complaints about the services I and my staff provide. Both recommendations will be implemented.

8. Annual Equality Report

Under the Equality Act 2010 and the Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011 laid down by the National Assembly for Wales, the Ombudsman is required to produce an annual report in respect of equality matters. I do so here as part of my overall Annual Report for 2015/16.

A commitment to treating people fairly is central to the role of an ombudsman. As Public Services Ombudsman for Wales, I am committed to providing equal opportunities for staff in the service provided to complainants. No job applicant, staff member or person receiving a service from the Ombudsman will be discriminated against, harassed or victimised due to personal characteristics such as age, disability, ethnicity, sex, gender reassignment, pregnancy or maternity, sexual orientation, religion or belief, whether they are married or in a civil partnership, or on the basis of any other irrelevant consideration. My staff are expected to share my total opposition to unlawful and unfair discrimination and the commitment to conducting business in a way that is fair to all members of society.

Accessibility

As part of our process, we do our very best to identify as early as possible any individual requirements that may need to be met so that a service user can fully access our services and, in particular, we ask people to tell us their preferred method of communication with us.

During 2015/16, we gave particular focus to improving access to our service for people who are deaf or hard of hearing. A new British Sign Language (BSL) video is now available, which explains the Ombudsman's service, as well as how people who are deaf or hard of hearing can access that service. Subtitles in both English and Welsh also make the video accessible to those with hearing loss who are unable to understand BSL. This coincides with the provision of the new SignVideo interpretation service which allows BSL users to contact the Ombudsman for free, using fully-qualified live interpreters. Calls can be made using a videophone, laptop, PC, tablet or smartphone enabling BSL users to have improved access to the Ombudsman's services.

We have always tried to make reasonable adjustments where these will help people make and present their complaint to us. Well established examples are: providing correspondence in Easy Read; using Language Line for interpretation, where a complainant is not comfortable with making their complaint in English or Welsh; obtaining expertise to assist us to understand the particular requirements of complainants with certain conditions, such as Asperger's syndrome; and visiting complainants at their homes.

We produce key documents in alternative formats, such as CD/tape and Braille, and translate these into the eight key ethnic minority languages used in Wales. Our website has continually been developed from initially being upgraded A to AA compliant, and then other introductions such as: enhanced BrowseAloud service; embedding the GoogleTranslate service meaning that the PSOW website content pages are automatically translated into any one of over 100 languages on selection; and, most recently, the BSL video referred to above.

The Complaints Advice Team also continues to provide information on advocacy and advice organisations to those people who may need assistance in making their complaint to me. This information is also readily available on our website.

Equality Data Gathering/Monitoring – Service Users

We continued with our equality monitoring in respect of service users, which informs our annual outreach strategy. The outcome of the monitoring during 2015/16 in respect of the protected characteristic groups (as defined in the Equality Act) is set out below.

In view of the nature of the work of this office, we would expect the people who complain to me to, at the very least, mirror the national demographic position; in fact, we would expect the proportion of complainants from groups who could be considered to be at disadvantage or vulnerable to exceed the national picture. In respect of each of the questions we asked, those who completed the form were given the opportunity to respond 'Prefer not to say'.

The results below are not dissimilar to those of previous years and similarly I am relatively satisfied that in making comparisons with official data available (e.g. the Census 2011) the composition of our service users meets or exceeds national demographics in the way we would expect. This office has previously identified an area that appeared to be slightly underrepresented was the minority ethnic community. Progress had been made whereby we were matching the demographic (4% of the Welsh population according to the Census). However it is really good to see , from an awareness point of view, that of those who completed the equality monitoring form during 2015/16, 6% identified themselves as being from a minority ethnic background.

Protected characteristic group	Percentage Outcome
Age	
Under 25	3%
25-34	11%
35-44	20%
45-54	23%
55-64	22%
65-74	11%
75 or over	5%
Prefer not to say/No response	5%
Disability	
Yes	25%
No	64%
Prefer not to say/No response	11%
Health problem or disability limiting day-to-day activities?	
Yes, limited a lot	24%
Yes, limited a little	12%
No	53%
Prefer not to say/No response	11%
Gender reassignment	
Yes	0.5%
No	23%
Prefer not to say/No response	76.5%
Religion or belief	
No religion	40%
Christian (all denominations)	47%
Other religions	8%
Prefer not to say/No response	5%
Married or same-sex civil partnership	
Yes	47%
No	41%
Prefer not to say/No response	12%
Race/Ethnicity	
White	88%
Other ethnic background	6%
Prefer not to say/No response	6%
Sex	
Male	50%
Female	45%
Prefer not to say/ No response	5%
Sexual orientation	
Heterosexual or straight	84%
Gay or Lesbian	1%
Bisexual	1%
Other	1%
Prefer not to say/No response	13%

Outreach

We take the results from our equality monitoring into account when developing our outreach programmes. We gave focus to two areas in particular during 2015/16: older people and people who are deaf or hard of hearing. With both equality and accessibility considerations in mind, we have also been giving attention to poverty/social exclusion as our research has indicated that awareness of the Ombudsman is low amongst this part of the Welsh population.

As part of this work my staff and I have engaged with the Wales Council for Voluntary Action; Tenant Participation Advisory Service, Shelter Cymru and I also chaired a meeting between the Welsh Government's Minister for Communities and Tackling Poverty, Michael Sheen (actor and campaigner) and housing charities in relation to youth homelessness. We have also engaged with organisations such as Action on Hearing Loss; Age Cymru and others.

Complaints Wales Signposting Service

I also view the Complaints Wales signposting service as important in relation to the office's contribution to the equality duty. This is an independent and impartial service delivered by the Complaints Advice Team to inform people where and how to put a complaint about a public service that provides the service they wish to complain about or to the appropriate independent complaint handler or ombudsman. I believe this to be an important service for those people who do not understand, are unfamiliar with, or feel disenfranchised from 'the public service system'. Promotion of the service continued during 2015/16, on this occasion through local/regional newspaper advertisements (both print and their associated online presence).

Our Casework

Our commitment and contribution to equality matters also manifests itself in our complaint handling work. We also have regard to matters of human rights. Whilst it is not for the Ombudsman to decide whether a public service provider is in breach of such legislation, it is possible that the failure to take account of any such legal obligations, or to follow policies and procedures designed to implement these obligations, will be maladministration. For example, following the investigation during the past year into a complaint about a homeless person, who was disabled and suffered from a post traumatic stress disorder, amongst other failings, I found that the time taken by the Authority to consider Mr A's housing application was out of kilter with the aims of the Equality Act. I made a number of recommendations. These included providing appropriate training for staff and ensuring that the special housing needs form and occupational therapy assessment processes are included in the Equality Impact Assessment tool to be used in Authority's new Allocation Scheme.

Training

We continue to provide relevant training to staff in relation to equality and human rights issues. I consider this important in relation to the service we provide to complainants, but also so that my staff are able to identify during our investigations any failings by public service providers in respect of their equality duties (as illustrated in a case example above). In particular, during 2015/16 I was grateful to members of the offices of the Northern Ireland Ombudsman and Northern Ireland Human Rights Commission for providing training to my staff on a manual they had jointly developed. The manual and the associated training will assist my staff in using a human rights-based approach in the decision to accept a complaint as well as investigating and reporting on the investigation.

Staff Equality Data Gathering/Monitoring

Our staff have been asked to complete and return a monitoring form seeking information in respect of each of the protected characteristics. We also now gather such information during our recruitment exercises. That disclosure is, of course, on a voluntary basis. The data held at 31 March 2016 is set out below.

Age	The composition of staff ages is as follows: 21 to 30: 17% 31 to 40: 29% 41 to 50: 31% 51 to 65: 23%
Disability	88% of staff said there were not disabled, no member of staff said that they were a disabled person (12% preferred not to say) However, when asked if their day-to-day activities were limited because of a health problem or disability which had lasted, or was expected to last, at least 12 months, 2% said that they were limited a lot, 2% said they were limited a little, 84% said their day to day activities were not limited (12% preferred not to say)
Nationality	In describing their nationality, 53% said they were Welsh; 25% said British, 10% said they were English, 2% said 'Other' (10% preferred not to say)
Ethnic group	The ethnicity of staff is: 81% White (Welsh, English, Scottish, Northern Irish, British); 2% White/Irish 3% Black (African, Caribbean, or Black British/Caribbean 2% Asian or Arian British/Bangladeshi (12% preferred not to say)
Language	When asked about the main language of their household, 73% of staff said this was English; 13% said Welsh, and 2% said 'Other' (12% preferred not to say)

Religion or Belief	Responses to the question asking staff about their religion were as follows: No religion: 39%; Christian 39%; Muslim 2%; Other:1% (19% preferred not to say)
Marriage/ Civil Partnership	When asked if they were married or in a same sex civil partnership, 49% of staff replied 'Yes'; whilst 32% said 'No' (19% preferred not to say)
Sexual Orientation	Responding on this, 75% said that they were Heterosexual or Straight, 2% said Gay or Lesbian (23% preferred not to say)

Under the specific duties we are required to set an equality objective for gender and pay; if we do not do so, we must explain why. I currently do not have any specific objective in this regard because females are very well represented at the higher pay scales within my office. The position is kept under continual review and the equality objectives will be revised if necessary. The table below shows the current the position.

Pay and Gender - data as of 31/03/2016

Pay (FTE)	**Male**	**Female**
Up to £20,000	1	4
£20,001 to £30,000	1	14
£30,001 to £40,000	2	4
£40,001 to £50,000	7	18
£50,001 to £60,000	4	3
£60,001 +	1	1
Subtotal	**16**	**44**
Total	**60**	

In relation to the working patterns of the above, all staff work on a full time basis with permanent contracts, with the exception of the following;

- 12 members of staff work part time (10 female, 2 male).
- 2 members of staff were employed on a fixed term contract.

Recruitment

During the past year we have had six members of staff leave. Seven new employees were recruited, five of these were to fill vacant posts and two were for the newly created positions of Communications & Policy Officers. Due to the low numbers involved, the equality data for the individuals appointed has been reported as part of the all staff information above; it is not considered appropriate to report separate equality information relating to these individuals due to the risk of identification

Equality data gathered from all of the past year's four recruitment exercises are as follows (note: totals showing 101% or 99% are a result of rounding):

Key

- **CWSO** – Casework Support Officer
- **PCO** – Policy and Communications Officer
- **IO/CO** – Investigation Officer and Casework Officer – joint recruitment panel.
- **APM** – Advisory Panel Member

		CWSO	PCO	IO/CO	APM	Total
Age	Did not say	3%	0%	6%	6%	4%
	under 25	34%	20%	28%	0%	21%
	25-34	36%	42%	35%	6%	30%
	35-44	18%	14%	21%	12%	16%
	45-54	8%	18%	10%	6%	11%
	55-64	1%	6%	0%	59%	17%
	65-74	0%	0%	0%	12%	3%
	75 and over	0%	0%	0%	0%	0%
		100%	100%	100%	101%	100%
Gender	Did not say	4%	0%	2%	0%	2%
	Male	32%	38%	42%	65%	44%
	Female	64%	62%	56%	35%	54%
		100%	100%	100%	100%	100%
Nationality	Did not say	1%	0%	3%	0%	1%
	Welsh	68%	64%	63%	35%	58%
	English	5%	6%	9%	6%	7%
	Scottish	1%	2%	3%	0%	2%
	Northern Irish	1%	0%	1%	6%	2%
	British	23%	27%	18%	53%	30%
	Irish	1%	0%	3%	0%	1%
		100%	99%	100%	100%	100%

		CWSO	PCO	IO/CO	APM	Total
Ethnic Group	Did not Say	3%	2%	8%	0%	3%
	White (Welsh/ Scottish/English/ NI/British)	93%	95%	81%	88%	89%
	White (Irish)	1%	2%	2%	6%	3%
	White (Gypsy/Irish traveller)	0%	0%	0%	0%	0%
	White (Other)	0%	0%	0%	6%	2%
	Asian /Asian British	2%	2%	6%	0%	3%
	Black, African, Caribbean or Black British	0%	0%	3%	0%	1%
	Mixed or multiple ethnic group	1%	0%	0%	0%	0%
	Other ethnic Group	0%	0%	0%	0%	0%
		100%	101%	100%	100%	100%
Language	Did not say	2%	0%	2%	0%	1%
	English	95%	94%	93%	94%	94%
	Welsh	0%	0%	0%	0%	0%
	Bilingual (Welsh / English)	3%	6%	5%	6%	5%
	Other	0%	0%	0%	0%	0%
		100%	100%	100%	100%	100%
Disability	Did not say	2%	2%	3%	0%	2%
	Yes	2%	2%	1%	6%	3%
	No	97%	97%	96%	94%	96%
		101%	101%	100%	100%	101%
Limited Activities	Did not say	2%	2%	3%	0%	2%
	Yes, limited a little	1%	0%	0%	0%	0%
	Yes, limited a lot	0%	0%	0%	0%	0%
	No	97%	98%	97%	100%	98%
		100%	100%	100%	100%	100%

		CWSO	PCO	IO/CO	APM	Total
Religion	Did not say	7%	6%	12%	0%	6%
	None	64%	61%	59%	12%	49%
	Christian	29%	32%	29%	88%	45%
	Buddjist	0%	0%	0%	0%	0%
	Hindu	0%	0%	0%	0%	0%
	Jewish	0%	2%	0%	0%	1%
	Muslim	0%	0%	0%	0%	0%
	Sikh	0%	0%	0%	0%	0%
	other	0%	0%	0%	0%	0%
		100%	101%	0%	0%	50%
Married or civil partnership	Did not say	5%	0%	7%	12%	6%
	Yes	12%	35%	16%	71%	34%
	No	83%	64%	77%	18%	61%
		100%	99%	100%	101%	100%
Sexuality	Did not say	15%	2%	19%	0%	9%
	Heterosexual	77%	89%	74%	100%	85%
	Gay or Lesbian	6%	5%	7%	0%	5%
	Bisexual	2%	5%	0%	0%	2%
	Other	0%	0%	0%	0%	0%
		100%	101%	100%	100%	100%

*excludes internal promotion

Staff Training

The majority of staff training is based upon job roles or applicable for all staff to attend, and as such there are no equality considerations to report. All individually requested training by staff has been approved, and as such there is no need to report on equality data differences between approved and non-approved training requests.

Disciplinary / Grievance

Due to the small numbers of staff working in the office, and the small number of instances of disciplinary / grievance, it is not considered appropriate to report on equality data for this category due to the risk of identification of staff involved. I remain satisfied that there are no identifiable issues in this area that would cause me concern.

Procurement

Our procurement policy now refers to the relevant equality requirements that we expect our suppliers to have in place.

Annex A

Public Body Complaints

Public Interest Reports: Case Summaries

Health

Abertawe Bro Morgannwg UHB – Issued March 2016 – Case Ref 201501032

Miss X said that her brother, Mr X, suffered from a congenital heart defect ("ACHD") and had surgically treated kyphoscoliosis (a condition in which the spinal column is convex both backward and sideways). She complained about the insufficient regularity of investigations, notably Echocardiagrams (a diagnostic test that uses ultrasound waves to make images of the heart chambers, valves and surrounding structures) ("ECHOs"), leading up to October 2011. She said that if ECHOs had been carried out every six months, treating clinicians might have detected a sub aortic membrane (a form of fixed sub aortic obstruction in which a fibrous membrane is located below the aortic valve) earlier than January 2012.

Miss X also complained that her brother could not be put on the waiting list for surgery until all tests and investigations had been completed and this took 11 months. She said that her brother should have been given priority due to his kyphscoliosis and the effect this had on his ability to expand his lungs. Miss X said that this would not have been an issue had the investigative tests been undertaken within a reasonable time. She said that the failure to undertake ECHOs far more frequently and to undertake investigative tests within a reasonable time meant that her brother did not receive surgery in time to save his life. Mr X was 57 years old when he passed away.

I concluded that there was no evidence to suggest that ECHO tests should have been undertaken more frequently. This was in light of the fact that the degree of obstruction caused by Mr X's sub aortic membrane (the narrowing of the left ventricle of the heart just below the aortic valve through which blood must pass) would have been unlikely to have been detected earlier than January 2012, which prompted the need for surgery. Given that there was no significant deterioration in Mr X's condition between October 2011 and December 2012, I found no failing in the level of priority that the Health Board gave Mr X for surgery. I upheld the complaint about the clinical advice given to Mr X during his wait for surgery. There was no evidence that Mr X was made aware of worrying symptoms. I upheld the complaint regarding Mr X's wait for treatment.

Treatment should have been supplied within 26 weeks, but Mr X was not due to receive treatment until 50 weeks had elapsed. Had Mr X received surgery more promptly, on the balance of probabilities, his death would have been avoided. I therefore took the view that Mr X's death was avoidable.

I made the following recommendations:

(a) that the Health Board's Chief Executive personally apologises to Miss X for the failings identified in my report, most notably, Mr X's avoidable death.

(b) that the Health Board concludes its "mirror" process to that conducted under the "Putting Things Right" ("PTR") in order to assess the level of compensation that it should offer to Mrs X in respect of the avoidable death of Mr X. The Health Board has confirmed that the file has already been shared with its legal department for this purpose and, with that in mind, it should conclude this process within three months of the date of issue of the report.

(c) that the Health Board ensures that the British Heart Foundation leaflet entitled 'Heart Valve Disease' is given to every relevant patient at clinic and that the checklist is completed to reflect this, and that appropriate advice has been given. The Health Board should ensure that all Cardiology clinicians are aware of this requirement. Confirmation that all relevant clinicians are aware of the leaflet, have sufficient copies and are aware when it should be used, should be provided to my office within two months of the date of the report.

The Health Board agreed to implement the recommendations.

Betsi Cadwaladr UHB - Issued October 2015 – Case Ref 201405067

Mrs P complained about her late husband Mr P's treatment in what were his final weeks and about the handling of her complaint. Specifically, she complained about a delay in Mr P being seen on admission to hospital due to a bed shortage, a failure in diagnosing his brain cancer from a scan performed, and failures in his care and treatment (including being given a drug of limited prognostic benefit). Mrs P also complained about how Mr P was afterwards discharged home to her care without appropriate plans and services in place. She further complained about his discharge with medication (about which no advice or guidance had been offered) and also about a letter written to her by the Consultant treating Mr P after his death, which had caused her further distress.

Following an examination of clinical records, and advice from my clinical advisers, the following aspects of the complaint were not upheld: Whilst Mr P's brain cancer had not been diagnosed from the scan this was within acceptable clinical practice on the part of an average radiologist, given the type of cancer was rare. However, given Mr P's ongoing symptoms, consideration should have been given to a second opinion from a Neuroradiologist. Whilst recognising Mrs P's distress in receiving the letter, at an emotional time, the Consultant had written it with the best of intentions. It was not, to the objective eye, insensitive or meant to cause her distress.

The following complaints were upheld: There had been a delay in Mr P's admission. The course of clinical treatment offered to Mr P at that stage of his illness was not reasonable (given its slow response rate) in comparison with a treatment he could have been offered which may have prolonged his life expectancy even for a short time. Mr P was discharged home without proper arrangements in place. The discharge lacked effective communication with both Mr and Mrs P, and raised serious concerns surrounding controlled medication. The complaint handling concern was also upheld.

The following recommendations were made, all of which the Health Board agreed to implement in full:

(a) a written apology to Mrs P and an offer of redress of £3,000 for her distress, time and trouble in pursuing her grievances and complaint handling delays;

(b) the preparation of an action plan dealing with the nursing care failings identified by my clinical adviser (relating to clinical care, patient discharge and record keeping);

(c) the case should be discussed at both Radiology and Cancer services meetings as a learning point, taking into account the critical comments of my clinical advisers. An action plan to deal with resulting actions to avoid recurrence should be prepared and shared with me.

Cardiff & Vale UHB – Issued June 2015 – Case Ref 201401302

Dr A complained about the care given to his mother ("Mrs A") by Cardiff and Vale University Health Board ("the Health Board"). He said that, on 13 February 2014, Mrs A was admitted to the Medical Assessment Unit ("the MAU") of the University Hospital of Wales. She was later transferred to a surgical ward ("the Ward"). Dr A said Mrs A was triaged wrongly, the medical team were late in examining her and no treatment was given. He said the MAU misdiagnosed and mismanaged sepsis and failed to follow the "sepsis pathway". He also said:

- antibiotics were either administered late or not at all;
- fluid balance monitoring was not done. His mother was septic and was unable to pass urine, but a catheter was not inserted;
- no paracetamol was given in the MAU and she remained feverish throughout her stay in the MAU;
- despite being on oxygen when she was in the MAU, she was not given oxygen during a transfer between the MAU and the Ward.

Dr A said the failings led to Mrs A suffering a cardiac arrest on 13 February. Mrs A remained in hospital until 8 March when, sadly, she died.

My investigation considered the relevant records along with comments from the Health Board and Dr A. I also obtained advice from two of my clinical advisers.

Sepsis is a common and potentially life-threatening condition triggered by an infection. If not treated quickly, it can eventually lead to multiple organ failure and death. Early symptoms of sepsis usually develop quickly and it can move from a mild illness to a serious one very quickly. Therefore, early intervention is key. If identified and treated quickly, sepsis is treatable. The Sepsis Six is a recognised set of interventions (including the giving of antibiotics) which, when delivered in the first hour, can increase the chance of survival.

My investigation found that Mrs A was suffering from sepsis. However, the Health Board failed to implement the Sepsis Six.

Mrs A should have been seen by a doctor within 10 minutes of triage; however she was not reviewed by the doctor for three and a half hours. There was a similar delay in the giving of paracetamol and, more seriously, a delay of over six hours in the giving of antibiotics.

My investigation also found that the Health Board failed to follow record keeping and complaint handling guidance.

In relation to Dr A's complaint that Mrs A was not given oxygen during a transfer between the MAU and the Ward, it is clear that Mrs A needed supplementary oxygen and this was given in the MAU. However, it was not clear from the records whether this was provided during the transfer to the Ward. If Mrs A was transferred without oxygen this would be a serious failing. The records indicated that she was peripherally cyanosed shortly after the transfer. This fits with the possibility that she was transferred without oxygen. She then suffered a cardiac arrest.

Unfortunately, as a result of poor record keeping, my investigation could not determine with any certainty whether Mrs A was, or was not, given oxygen during the transfer. Nor could it definitively identify what role the transfer played in her suffering a cardiac arrest. The poor record keeping therefore caused uncertainty which is an injustice.

I concluded that the care provided to Mrs A on 13 February was inadequate. Therefore, I upheld Dr A's complaint and recommended that the Health Board should:

(a) give Dr A an unequivocal written apology for the failures identified by this report

(b) make a payment to Dr A of £4,000 to reflect the:
  i. distress caused by the failings in Mrs A's care;
  ii. uncertainty caused by those failings;
  iii. failings in the Health Board's handling of his complaint;
  iv. provision of incorrect information during the complaint process

(c) so that appropriate lessons may be learned, share this report with the doctors, nurses and administrative staff involved in the case

(d) formally remind the doctors and nurses involved in Mrs A's care to follow the relevant record keeping guidance. (If needed, and within four months of the date of this report, the Health Board should implement refresher training for staff, involved in the case, who indicate that they are not fully conversant with the relevant guidance)

(e) provide me with evidence of its current process which ensures that doctors and nurses who meet with complainants are familiar with the case and the patient's records

(f) provide me with evidence of the existing monitoring and quality assurance mechanisms it has in place to prevent a recurrence of the failure of:

i. doctors to review a patient categorised as triage 2 within the timescales specified by the MTS
ii. doctors and nurses to follow the sepsis pathway
iii. doctors to ensure that the surgical review was performed by a doctor experienced enough to perform it
iv. doctors and nurses to maintain appropriate records
v. doctors, nurses and administrative staff to follow the Complaints Guidance.

(If the Health Board is not able to provide evidence to show that it has current suitable protocols for (e) and (f)(i) – (v) then, within four months, it should provide its plans to introduce such protocols.)

(g) ensure that staff training in respect of recognising sepsis is up to date.

(If needed, and within six months of the date of the investigation report, the Health Board should implement training for staff who indicated that they were not fully conversant with the relevant protocols.)

Hywel Dda UHB & Welsh Ambulance Service Trust - Issued June 2015 – Case Refs 201400661 & 201402833

Mrs X complained about the care and treatment her late husband received from Hywel Dda University Health Board's ("the Health Board") out of hours service ("OOH") and Welsh Ambulance NHS Trust ("WAST") during the final stages of his life.

The investigation found that the Health Board had failed to ensure that there would be any OOH GP cover in the Pembrokeshire area on 15 July 2013. As a result of that failing Mr X had to wait three hours to be seen by a doctor, which is a significant period when experiencing pain and anxiety, particularly in the final hours of life. The failure to ensure adequate cover was in place put additional strain on the emergency services and placed the residents of Pembrokeshire at risk.

The investigation also found that following Mr X's sad death, the paramedic in attendance did not understand his responsibility under the "Recognition of Life Extinct" ("ROLE") policy which resulted in an unnecessary decision to call the Police. It was also noted that in response to Mrs X's complaint about this matter WAST endorsed the actions of the paramedic despite those actions being contrary to the ROLE policy.

I recommended that the Health Board apologise to Mrs X and her family and pay the sum of £1,000 in recognition of the distress and injustice arising from the identified service failure. I also recommended that the Health Board remind GPs of the need to ensure that a patient's

computerised "special notes" are completed and accessible by the OOH service and that "Just in Case Boxes" contain the necessary prescriptions. Finally, I recommended that the Health Board review its contingency plan for periods where there are no GPs available in the area and ensure that the OOH practitioners available have the necessary skills.

I recommended that WAST apologise to Mrs X and her family and pay the sum of £500 in recognition of the distress and injustice arising from the identified service failure. It was also recommended that paramedics and officers are reminded of their responsibilities under the ROLE policy and the Code of Practice. Finally it was recommended that WAST review its training plan to include training on the ROLE policy.

Education

Wrexham County Borough Council – Issued February 2016 – Case Ref 201403532

Mrs A complained that Wrexham County Borough Council ("the Council"), in its role as the local education authority ("LEA") failed to properly consider, assess and identify her son, B's, special educational needs ("SEN"). Mrs A said the LEA failed to consider whether B's SEN would be better provided for by a statutory assessment. Mrs A considered that the Extended School Action Plus Agreement ("ESAP") issued by the LEA for B was not monitored and the LEA failed to ensure that his school provided the support specified under that Agreement. Mrs A complained that the Council failed to properly handle her complaint about the LEA.

The investigation found that ESAP Agreements are not referred to, or recognised, either as part of a graduated approach or as an alternative to statutory assessment in any of the LEA's information, procedures and/or its published policies for SEN provision. I concluded that in B's case an ESAP Agreement, as an alternative to statutory assessment, was not a legitimate means of meeting B's SEN. The LEA's policy was clear when B's school based interventions were insufficient to meet his SEN requirements, B should have been considered for a statutory assessment. I was concerned about the LEA's use of ESAP Agreements as an alternative to statutory assessment.

The LEA argued that B's ESAP Agreement was on a par with an SEN Statement but the investigation concluded this was not the case. Further, the ESAP Agreement issued by the LEA was only in place for a two week period during which B attended school on significantly reduced hours. As such the ESAP provision was not met by the LEA.

I upheld Mrs A's complaint and concluded that the LEA failed to assess and identify B's SEN and failed to provide B with the appropriate support to meet his identified needs. I upheld

Mrs A's complaint about the way the Council handled her complaint, although the Council had subsequently made changes to its complaint management procedure to avoid a recurrence of the situation.

I recommended the Council apologise to Mrs A and provide redress of £350 for Mrs A's time and trouble in pursuing a complaint. It was also recommended that the Council identify and instruct an independent educational specialist to review educational provision to B; the Council review it's published SEN Policy; and the Council audit the ESAP Agreements currently in place to consider whether statutory assessments should be carried out in accordance with its SEN Policy.

Other

Cynwyd Community Council – Issued November 2015 – Case Ref 201403092

Mrs X complained about poor communications that the Council had with local residents. Mrs X said that it posted some notices in Welsh only and she was aggrieved that this excluded her from becoming involved with the Council as she does not speak Welsh. She said that, when the Council posted agendas in Welsh only, non-Welsh speakers were being disadvantaged because they did not know what would be discussed at those meetings.

Mrs X considered that the Council's meetings being held solely through the medium of Welsh also excluded her, because she would not understand what was being discussed. She felt that the way that the Council conducted its business detrimentally affected her ability to properly take part in local democracy.

Mrs X considered that the Council should ensure that all of its notices and meetings should be bilingual so that everyone could be involved and made to feel that their views and concerns were equally valid.

Whilst I fully accept and support the principle that the Council has a right to conduct its business through the medium of Welsh, I found that by posting agendas in Welsh only the Council had failed to make adequate written bilingual provision for Mrs X as a person who understands English, but not Welsh. That amounted to maladministration which caused Mrs X to suffer an injustice. I therefore upheld Mrs X's complaint. I recommended that:

(a) the Council apologise to Mrs X in writing for failing to make adequate written bilingual provision for her;

(b) the Council undertake to publish all agendas bilingually and to make other documents available bilingually (including meeting minutes if they were not already available bilingually) where reasonably practicable to do so.

The Council did not accept the findings of the report and refused to implement the recommendations made.

I had also recommended in an earlier draft of this report that the Council should make a payment of £100 to Mrs X in recognition of the time and trouble she had expended pursuing her complaint. Mrs X, having seen the draft, said that she was disinclined to accept the money. I therefore did not ask the Council to make such a payment to Mrs X, although I considered it would be merited.

[Note: Subsequent to the publication of the above report, the Community Council met and agreed to implement my recommendation at (b) above.]

Annex B

Public Body Complaints:
Statistical Breakdown of Outcomes by Public Body

Note: Complaints included in the category 'Other cases closed after initial consideration' on the pages which follow, consists of those received which:

- did not provide any evidence of maladministration or service failure,
- did not provide any evidence of hardship or injustice suffered by the complainant,
- showed that little further would be achieved by pursuing the matter (for example, a public body may have already acknowledged providing a poor service and apologised).

County/County Borough Councils

County/ County Borough Council	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Blaenau Gwent	3	8	5	1	1		1			**19**
Bridgend	4	18	17		1				2	**42**
Caerphilly	10	17	24		2		1	1	1	**56**
Cardiff	15	46	58		20		2	1	1	**143**
Carmarthenshire	8	12	18		8		2	3		**51**
Ceredigion	7	12	6	1	5		2			**33**
Conwy	3	5	10		2					**20**
Denbighshire	7	10	17	2	1		2	1	1	**41**
Flintshire	4	18	14		2		3			**41**
Gwynedd	7	4	11	1	4		1	1		**29**
Isle of Anglesey	2	14	12				4	1		**33**
Merthyr Tydfil	1	5	5	1	4				1	**17**
Monmouthshire	7	7	9				1			**24**
Neath Port Talbot	5	14	16		1			1	1	**38**
Newport	1	10	14	1	4		1	4		**35**
Pembrokeshire	6	17	17		4		1		1	**46**
Powys	13	20	16		5		7	1	1	**63**
Rhondda Cynon Taf	9	11	19		3					**42**
Swansea	12	9	19		2		1		1	**44**
Torfaen	2	4	9		1			1		**17**
Vale of Glamorgan	6	14	19		3					**42**
Wrexham	6	17	21		8	1	2		1	**56**
Total	138	292	356	7	81	1	31	15	11	**932**

Other Local Authority

School Appeal Panels	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Croesty Primary School			1							**1**
Cardiff High School			1							**1**
All Saints Church in Wales Primary School - Admissions Authority							1			**1**
All Saints Church in Wales Primary School - Appeal Panel							1			**1**
Beaufort Hill Primary			1							**1**
Mary Immaculate Catholic High School			1							**1**
Rogerstone Primary School			2							**2**
Rumney Primary School			1							**1**
Ysgol Gynradd Llanelltyd			1							**1**
Ysgol Gyfun Gymraeg Plasmawr			1							**1**
Bishopston Comprehensive School			1							**1**
Fitzalan High School			1							**1**
Penarlag Primary School								1		**1**
Mount Stuart Primary School			1							**1**
Total			12				2	1		**15**

Other Local Authority (Continued)

National Park Authority	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Brecon Beacon	1	1	3		1					**6**
Pembrokeshire Coast		1	2		1					**4**
Total	1	2	5		2					**10**

Fire & Rescue	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Mid and West Wales			1							**1**
South Wales	1									**1**
Total	1		1							**2**

Community/Town Councils

Community or Town Council	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Abergavenny Town			1							**1**
Aberystwyth Town	1									**1**
Bangor City		1								**1**
Cornelly Community		1								**1**
Corris Community			1							**1**
Cwmamman Town		1								**1**
Cynwyd Community						1				**1**
Glynneath Town	1	2								**3**
Holyhead Town	2									**2**
Llanddew Community		1								**1**
Llanfynydd Community [Carmarthenshire]			1							**1**
Llangattock Community			1							**1**
Llantwit Fardre Community		1								**1**
Llywel Community			1							**1**
Neath Town		1	6							**7**
Raglan Community							1			**1**
Rhosllanerchrugog Community		1								**1**
Sully and Lavernock Community	1									**1**
Trefeglwys Community	1									**1**
Welsh St Donats Community			1							**1**
Ynysawdre Community	1	1								**2**
Total	7	10	12			1	1			**31**

Registered Social Landlords

Housing Association (Registered Social Landlord)	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Abbeyfield, South Wales Society	1									**1**
Bro Myrddin			2							**2**
Bron Afon Community Housing Ltd	1	3	1							**5**
Cadarn Housing Group Ltd		1								**1**
Cadwyn Housing Association Ltd		1	2							**3**
Cardiff Community			1		1				2	**4**
Cartrefi Conwy		3	1							**4**
Cartrefi Cymunedol Gwynedd	2	3	10		2				1	**18**
Charter Housing		4	4							**8**
Clwyd Alyn	2		4		3					**9**
Coastal Housing Group Ltd		1								**1**
Cymdeithas Tai Cantref							1			**1**
Cynon Taf Community Housing		1								**1**
Derwen Cymru					2					**2**
Family Housing Association (Wales) Ltd		1								**1**
First Choice Housing Association Ltd		1								**1**
Grwp Cynefin			1							**1**
Grwp Gwalia Cyf Ltd	2	1	6		1					**10**

Registered Social Landlords (Continued)

Housing Association (Registered Social Landlord)	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Hafod	1	2	5							**8**
Hendre		1								**1**
Linc-Cymru		2			2					**4**
Melin Homes Ltd		2	2							**4**
Merthyr Tydfil Housing Association Ltd		1								**1**
Merthyr Valleys Homes	2	1	2						1	**6**
Mid Wales Housing Association Ltd	2				1					**3**
Monmouthshire		2								**2**
Newport City Homes		3	4		1					**8**
Newydd			1							**1**
North Wales Housing		2	1		1					**4**
NPT Homes	2	5	7							**14**
Pembrokeshire Housing Association Ltd	1	1	2							**4**
RCT Homes		4	2							**6**
Rhondda Housing Association Ltd	1	1							1	**3**
Tai Calon		1								**1**
Tai Ceredigion Cyf	1	1	2							**4**
United Welsh		3	1		1					**5**
Valleys To Coast		1	1		1					**3**
Wales and West	1	3	3							**7**
Total	19	56	65		16		1		5	**162**

Local Health Boards and NHS Trusts

Local Health Board/ NHS Trust	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Abertawe Bro Morgannwg	15	21	33	2	12	1	16	10	5	**115**
Aneurin Bevan	9	15	28		12		21	9	3	**97**
Betsi Cadwaladr	11	27	40		24	1	21	8	3	**135**
Cardiff and Vale	7	17	22		14	1	16	5	3	**85**
Cwm Taf	4	12	18		12		11	10		**67**
Hywel Dda	7	27	18	1	32	1	14	1	1	**102**
Powys Teaching	3	3	17	1	6			9	1	**40**
Public Health Wales		1	1		1					**3**
Velindre	1						1			**2**
Welsh Ambulance Services	3	4	6			1	2			**16**
Total	60	127	183	4	113	5	102	52	16	**662**

Other Health Bodies

Other Health	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Dentists		11	7		5		3	2	4	**32**
GPs	7	26	29	5	2		16	31	1	**117**
Pharmacist					1			1		**2**
Total	7	37	36	5	8		19	34	5	**151**

Welsh Government and Welsh Government Sponsored Bodies

Welsh Government and Welsh Government Sponsored Bodies	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Welsh Government										
CAFCASS Cymru		2	4		1		1			**8**
CSSIW			3		1		1	1		**6**
Healthcare Inspectorate Wales					1					**1**
Independent Complaints Secretariat	1									**1**
Planning Inspectorate			5				1			**6**
Welsh Government	4	7	6	1	3		1	1		**23**
Welsh Health Specialised Services Committee		1	3							**4**
Total	5	10	21	1	6		4	2		**49**

Welsh Government Sponsored Body										
Higher Education Funding Council for Wales (HEFCW)			1							**1**
Natural Resources Wales	2	5	1				1			**9**
Student Finance Wales		1	1		1					**3**
Welsh Language Commissoner			1							**1**
Total	2	6	4		1		1			**14**

Independent Care Providers

Independent Care Providers	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Marjorie Kirby (Warrendale Cottage Residential Home)			1							**1**
NHS Independent Care										
Glanbury Care Home				1						**1**
Nant y Gaer Hall Nursing Home								1		**1**
Self Funding Independent Care										
Craig Y Trwyn Care Home				1						**1**
Gofal Gwynedd Care Ltd			1							**1**
Hallmark Care Home Ltd							1			**1**
Hawthorn Court Care Home							1			**1**
Kinmel Lodge Residential Home			1							**1**
Springbank Nursing Home	1									**1**
Trewythen Hall Care Home									1	**1**
Lakeside House Nursing Home		1								**1**
Loving Care									1	**1**
The Oaklands Residential Home									1	**1**
Sevacare			1						1	**2**
Torestin Care Home Ltd (Brynderwen Care Home Ltd)			1							**1**
Ty Porth Care Home		1								**1**
TOTAL	1	2	5	2			2	1	4	**17**

Other

Other	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
National Assembly for Wales Commission	1									**1**
Body out of jurisdiction	4									**4**
TOTAL	5									**5**

Annex C

Code of Conduct Complaints:
Statistical Breakdown of Outcomes by Local Authority

County/County Borough Councils

County/County Borough Council	Closed after initial consideration	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Blaenau Gwent	3							**3**
Bridgend	9							**9**
Cardiff	14		1				2	**17**
Carmarthenshire	3	3	1	1				**8**
Conwy	2							**2**
Denbighshire	5							**5**
Flintshire	1							**1**
Gwynedd	6							**6**
Isle of Anglesey	1	1						**2**
Monmouthshire	4		1	1				**6**
Neath Port Talbot	2							**2**
Newport	2							**2**
Pembrokeshire	5		1	2				**8**
Powys	13							**13**
Rhondda Cynon Taf	3		1					**4**
Swansea	11							**11**
Torfaen	5		1					**6**
Vale of Glamorgan	6					1		**7**
TOTAL	95	4	6	4		1	2	**112**

Community/ Town Councils

Community/Town Council	Closed after initial consideration	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Abergavenny Town			1					**1**
Abertillery & Llanhilleth Community	17							**17**
Aberystwyth Town	1						1	**2**
Amroth Community		1						**1**
Bangor City	1							**1**
Bargoed Town	1							**1**
Barry Town						1		**1**
Brackla Community	1						1	**2**
Bronwydd Community	1							**1**
Buckley Town	1							**1**
Builth Wells	1							**1**
Caldicot Town	2							**2**
Connah's Quay Town				1				**1**
Crickhowell Town	1							**1**
Devauden Community	1							**1**
Dinas Powys Community					2			**2**
Fishguard & Goodwick Town	1							**1**
Garw Valley Community	4	1					1	**6**
Glynneath Town	22							**22**
Gorseinon Town	2							**2**
Gwehelog Fawr Community	1							**1**
Holyhead Town	14							**14**

Community/ Town Councils (Continued)

Community/Town Council	Closed after initial consideration	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Llanddew Community	6							**6**
Llanedi Community		1						**1**
Llanelli Rural	2		1					**3**
Llanelli Town				1				**1**
Llanfynydd Community [Carmarthenshire]							1	**1**
Llanfynydd Community [Flintshire]				1				**1**
Llangattock Community	1							**1**
Llangefni Town	2							**2**
Llanover Community		1						**1**
Llansteffan & Llanybri Community				1				**1**
Llantilio Pertholey Community	3						7	**10**
Llantwit Fardre Community	1							**1**
Llanwrtyd Wells Town		2						**2**
Llywel Community	1							**1**
Magor with Undy Community						1		**1**
Manorbier Community	1		2		1			**4**
Merlins Bridge Community	1							**1**
Mumbles Community	5							**5**
Neyland Town							1	**1**
Northop Community	1							**1**

Community/ Town Councils (Continued)

Community/Town Council	Closed after initial consideration	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Penmaenmawr Town			1					**1**
Pontyclun Community	1							**1**
Porthcawl Town	1						1	**2**
Radyr and MorganstownCommunity	5							**5**
Saltney Town	1							**1**
Towyn & Kinmel Bay Town	2							**2**
Trefeglwys Community				1				**1**
Tywyn Town	6			1				**7**
Welsh St Donats Community	2							**2**
Welshpool Town	3							**3**
TOTAL	117	6	5	6	3	2	13	**152**

National Park Authorities

National Park Authority	Closed after initial consideration	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Brecon Beacons	1							**1**

Public Services Ombudsman for Wales
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Report of the Deputy Monitoring Officer

Standards Committee – 7 October 2016

THE CODE OF CONDUCT CASEBOOK

Purpose:	The report presents the Public Service Ombudsman for Wales Code of Conduct Casebook for July 2016
Report Author:	Tracey Meredith
Finance Officer:	Ben Smith
Legal Officer:	Tracey Meredith
Access to Services Officer:	Phil Couch
FOR INFORMATION	

1. Background

1.1 The Ombudsman has recently published the Code of Conduct Casebook for the period April to June 2016 which is attached at Appendix A.

2. Equality and Engagement Implications

There are no equality and engagement implications associated with this report.

3. Legal Implications

3.1 There are no legal implications associated with this report.

4. Financial Implications

4.1 There are no financial implications associated with this report.

FOR INFORMATION

Background papers: None

Appendices: Appendix A Code of Conduct Casebook

Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

The Ombudsman's
Casebook

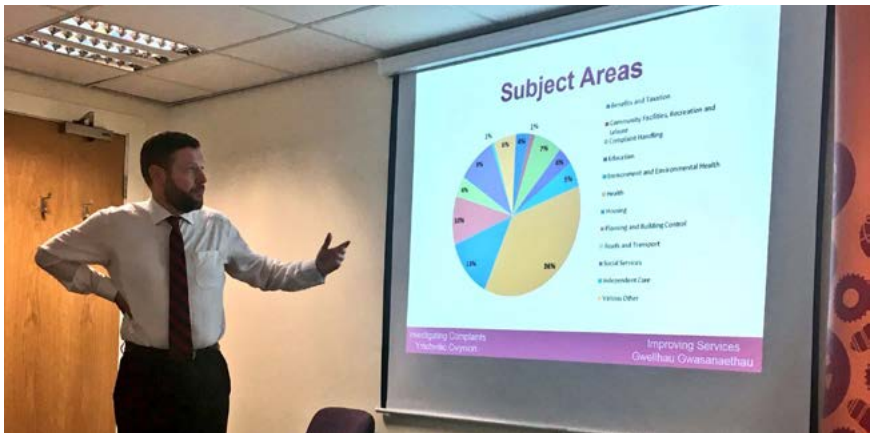
Issue 25 July 2016

News

Embracing Complaints

The Ombudsman was the principal speaker at two Wales Audit Office seminar events in North and South Wales, attended by more than 90 people.

He spoke about trends in public service complaints, governance, empowering staff to resolve complaints and the importance of organisational culture in handling complaints.



Sounding Board Launched

June saw the inaugural meeting of our Service User Sounding Board which was set up to gather feedback on our services and processes as well as facilitate two-way communication with third sector stakeholders.

Attendees included representatives from Age Cymru, Citizens Advice and Shelter. The group gave useful feedback on a variety of topics including improving transparency in our equality data capture around diversity and the role of advocates in supporting our customers.

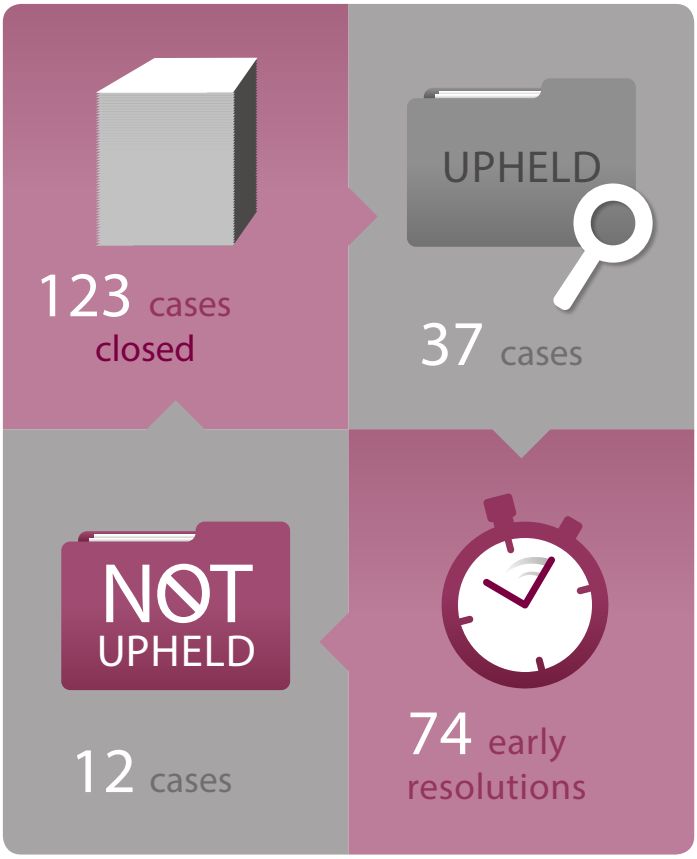
Welsh NHS Complaints Up Four Per Cent, New Ombudsman Figures Reveal

Complaints made against Welsh NHS bodies to the Public Services Ombudsman for Wales have risen by four per cent over the past year, according to new figures

The Ombudsman, Nick Bennett, called for stronger leadership to "turn the curve" of complaints and said new Assembly legislation for his office was needed to improve public services in Wales. The 2015/16 annual report can be accessed here.

Contents

Casebook in numbers



This infographic illustrates the cases closed between April and June 2016. It does not include enquiries or complaints deemed premature (where public bodies have not been given the opportunity to resolve a complaint locally) or out of jurisdiction.

Please note the early resolutions category also includes voluntary settlements.

Health

The following summary relates to a public interest report issued under Section 22 of the Public Services Ombudsman (Wales) Act 2005.

Hywel Dda University Health Board – other

Case Reference 201600223- Report issued in May 2016

Ms A had complained to Hywel Dda University Health Board ("the Health Board") in June 2014 concerning her son's opthalmic care, but had not received a response to the complaint. She complained to the Ombudsman in January 2016, asking him to investigate the Health Board's handling of her complaint and secure a response. In accordance with his powers, the Ombudsman resolved the complaint (as an alternative to investigation) on the basis of the Health Board's agreement to a number of actions, including an apology, financial redress for the complaint handling delays, and confirmation as to when the written response would be sent. These actions were to be completed by 15 March 2016.

Being dissatisfied that the Health Board had not complied with the earlier recommendations, the Ombudsman invoked his powers to issue a special report. This was critical of the Health Board's actions in the meantime and its failure to implement the recommendations it had previously agreed to. Therefore, the Ombudsman made further recommendations:

(a) issue the complaint response to Ms A without further delay

(b) issue an additional written apology to her for the continued delay

(c) offer Ms A further financial redress of £100 for that delay

(d) provide copies of the letters to the Ombudsman.

(e) the Chief Executive should personally respond to the Ombudsman after undertaking a review of the resources within the Concerns Team and its capacity to deal with the number of complaints received in a timely way.

OTHER REPORTS - UPHELD

Cardiff and Vale University Health Board - Clinical treatment outside hospital
Case reference 201502118 – Report issued in April 2016

Ms D complained to the Ombudsman that the Cardiff and Vale University Local Health Board ("the Health Board") Community Mental Health Teams had failed to share her care and treatment plan (CTP) with her for her input and agreement. She was also concerned that appointments with her Community Mental Health Nurse had been cancelled unreasonably at short notice and with no explanation and that communication with her had been poor.

The Ombudsman found that Ms D's CTP had been completed without Ms D's involvement and that this was unreasonable. Whilst the impact of this failing on the care provided to Ms D seems to have been minimal, it could have caused her distress and could impact on her willingness to engage with the service in future. The Ombudsman upheld this aspect of the complaint. The Ombudsman found that other elements of care provided to Ms D were reasonable and therefore these aspects were not upheld.

The Ombudsman recommended that the Health Board:

a) apologise to Ms D

b) provide her with redress of £300, and

c) undertake and expand its regime of casework audits, shares the outcome of these with him and arrange for staff to receive training where indicated.

Cwm Taf University Health Board - Clinical treatment in hospital
Case reference 201502860 – Report issued in April 2016

Mr X complained about the care his late mother (Mrs A) received in Ysbyty Cwm Rhondda over a period of some months. He said that she did not receive appropriate treatment because the deterioration in her condition was not recognised, and there was a delay in calling an ambulance for her to be transferred to the Royal Glamorgan Hospital. He also said that there had been no discussion with the family about a possible DNAR order, despite the records documenting that this should be done.

The Ombudsman partly upheld the complaint. He found that Mrs A had been seriously ill and had received appropriate treatment for her condition, although her family had not been made aware of how ill she was. There should have been a DNAR order in place; if there had been, Mrs A would have received appropriate end of life care, and would not have been transferred to the Royal Glamorgan Hospital.

However, the Ombudsman found that, sadly, the outcome would have been the same. He recommended the Health Board:

a) apologise to Mr X

b) pay him £750 in recognition of the distress cause, and

c) review its criteria for ensuring patients are suitable for transfer to community hospitals, and that the case be discussed at the Consultant's annual appraisal.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital
Case reference 201501497 - Report issued in April 2016

Mr A complained that his late mother, Mrs B, was incorrectly told that she had pancreatic cancer, causing her to "give up" and her health to deteriorate. The Ombudsman found that the record which the doctor made of the conversation showed that he warned that Mrs B might have cancer. It was reasonable for Mrs B to be told this, but she should have been told at the earliest opportunity that this was not the case. There was a delay in the outcome of the multi-disciplinary meeting being made available to clinicians, and there was no record of the family being told that Mrs B did not have cancer.

The Ombudsman found that there were failings in communication with Mrs B and her family, but Mrs B's belief that she had, or at least might have, cancer did not contribute to her deterioration. Mrs B was very unwell, and there was evidence she was depressed before this. The Ombudsman partly upheld the complaint.

The Ombudsman recommended that the Health Board:

a) apologise to Mr A

b) review its procedures for communicating the outcome of meetings to clinicians, and

c) remind staff of the importance of communication with patients and their families, and of the recording of discussions.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case reference 201502424 - Report issued in April 2016

Ms B complained about the post-operative nursing care her late father Mr B received while an inpatient at Glan Clwyd Hospital for a broken femur. Ms B stated that her father's leg had become trapped in a bed rail and he had suffered injury to both calves. Ms B also complained about Betsi Cadwaladr University Health Board's ("the Health Board") poor complaint handling which included delays in responding to her complaint.

The Ombudsman considered that Mr B's overall nursing care was reasonable and tailored to his needs. However, he said that there should have been an assessment of Mr B's risk of developing pressure ulcers with any existing wound documented and a care plan put in place to minimise any risk identified. Administratively, the Ombudsman was critical of the poor nursing records and the loss of part of Mr B's nursing records which meant that Ms B was denied an opportunity to have an independent review of her complaint by the Ombudsman. The Ombudsman was also critical of the excessive delays in dealing with Ms B's complaint. He upheld these aspects of Ms B's complaint. The Ombudsman recommended that the Health Board:

a) apologise to Ms B for the failings identified by the investigation

b) pay her the sum of £500 for the loss of records and £250 for the delay in complaint handling, and

c) remind staff about their professional obligation to keep proper records in accordance with the Nursing and Midwifery guidance.

Cwm Taf University Health Board – Clinical treatment in hospital
Case reference 201409047 – Report issued in April 2016

Mr J complained about the medical and nursing care and treatment provided to his late mother, Mrs J, during her admission to the Royal Glamorgan Hospital in February 2013. He also complained about communication with the family, raising particular concerns about communication and discussion regarding a Do Not Attempt Cardiopulmonary Resuscitation ("DNACPR") decision. He complained that Mrs J was not given adequate fluids and, again, about poor communication about these issues. He was concerned about the standard of record keeping, pointing to inaccuracies in the National Early Warning Score ("NEWS") charts and the fact that nursing records went missing following his mother's death.

Following investigation, the Ombudsman concluded that clinical treatment was reasonable, but that there were shortcomings in communication with the family and a failure to involve the family in important decisions. There were also some failings in the level of nursing care provided and in record keeping. Finally, Cwm Taf University Health Board ("the Health Board") had not dealt appropriately with Mr J's complaint.

The Ombudsman made a number of recommendations to address these shortcomings. These included:

a) highlighting the importance of proper discussion with the family prior to any DNACPR decisions at departmental meetings

b) involving family members in palliative care discussions

c) ensuring appropriate observations and recording of scores

d) reminding staff of the need to comply with NMC guidance in record keeping and to handle complaints in accordance with the required timescales, and

e) that the Health Board apologise to Mr J and make a payment to him of £600 in recognition of the poor complaints handling and the distress caused by the communication and record keeping failings in this case.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital
Case reference 201502878 – Report issued in April 2016

Miss M complained about the care and treatment her late sister, Miss B, received at Singleton Hospital. Miss M had concerns about how her late sister's cancer care had been managed, these included problems with provision of medication, diagnosis, record keeping and basic nursing care.

Advice was taken from the Ombudsman's Professional Advisers for oncology and nursing. The Ombudsman was satisfied that the medical care had been satisfactory but found that there were failings in relation to Miss B being discharged without some medication, and in nursing care, record keeping and communication with Miss M. The complaint was partly upheld.

Although Abertawe Bro Morgannwg University Health Board had already taken a number of measures to improve care on the ward in question, it accepted some further recommendations from the Ombudsman in relation to the completion of nursing assessments, management of medication, and documentation of patients' falls risk.

Hywel Dda University Health Board - Other
Case reference 201502092 – Report issued in April 2016

Ms A complained on behalf of Mr C, who had complex health needs, severe communication difficulties and learning disabilities, about a hospital discharge. She felt that the decision to discharge him was related to the decision not to fund one of his carers to stay with him. Ms A also complained about the delay in dealing with the complaint.

The Ombudsman found that whilst the decision to discharge Mr C was not clinically unreasonable, it should have been considered in the context of Mr C's overall needs. He found that the decision not to fund one of his carers to stay with him did not take sufficient account of Mr C's particular needs and did not appear to have been in his best interests. He upheld this complaint. The complaint about the delay in dealing with Ms A's complaint was also upheld.

The Ombudsman recommended that the Health Board:

a) apologise to Ms A for the poor complaints handling

b) offer her £400 redress in recognition of this and offer to meet with her to discuss the action it has taken to improve its care of patients with learning disabilities, and

c) review its arrangements for authorising requests for additional patient funding for patients with learning disabilities.

Powys Teaching Health Board - Continuing care
Case reference 201408376 – Report issued in April 2016

Mrs X complained about the way in which Powys Teaching Health Board ("the Health Board") managed her retrospective claim for NHS Funded Continuing Care ("NHSFCC").

The investigation found that the Independent Review Panel ("IRP") had failed to inform Mrs X of the process, in writing, before a negotiation meeting took place. The Ombudsman took the view that doing so would have enabled Mrs X to have made an informed decision about pursuing her claim. Secondly, despite the obvious relevance of the negotiation meeting notes, the IRP did not consider them before reaching its eligibility decision. The Ombudsman partly upheld the complaint. He recommended that the Health Board:

a) apologise to Mrs X

b) prepare an action plan detailing how it will address the failings identified,and

c) arrange for a fresh IRP to review the claim taking into account the negotiation meeting notes and the comments on the Clinical Adviser's revised eligibility recommendation during this review.

Cardiff and Vale University Health Board – Clinical treatment outside hospital
Case reference 201503114 – Report issued in May 2016

Mrs Y complained about the care and treatment that her husband (Mr Y) received following surgery to remove a tumour. Mrs Y said that a Doctor at an out-patient appointment in February 2015 had failed to take seriously her husband's comments and a scan was not organised in line with what they had been told to expect. She also complained that there had been a further delay/mix up in the arrangements for Mr Y to have a scan following the identification of a possible return of a tumour in May 2015. Mrs Y also expressed concern about Cardiff and Vale University Health Board's ("the Health Board") response to her complaint.

Having taken account of clinical advice, the Ombudsman found that the judgement made by the Doctor at the appointment in February was not wholly unreasonable and he did not uphold this aspect. Due to limitations in record keeping, the Ombudsman could not identify what exactly Mr and Mrs Y had been told previously to expect in terms of a treatment plan.

The Ombudsman upheld the complaint about the problems with the scan being organised in May and recognised that this caused additional stress for the family.

The Ombudsman partly upheld the concern about the Health Board's complaint response.

The Ombudsman recommended that the Health Board:

a) apologise to Mrs Y, and

b) provide financial redress of £1,500 for the distress caused and that it puts in place a more effective system of communication for managing scan requests.

Cwm Taf University Health Board - Clinical treatment in hospital
Case reference 201500534 - Report issued in May 2016

Mrs T complained about the treatment that Cwm Taf University Health Board ("the Health Board") gave her daughter, S, at the Royal Glamorgan Hospital ("the Hospital"), following a road traffic accident. S sustained a head injury as a result of this accident. Mrs T said that the Doctor, who had seen S, had not completed a full physical examination of her. She also reported that he had not arranged for a scan or X-rays of S's head to be taken before discharging her. She suggested that S should have had treatment for concussion at the Hospital.

The Ombudsman found that the Doctor's physical examination of S, during her general trauma assessment, was deficient because he had not demonstrated that he had undressed her and completed a thorough and systematic survey of her entire body. He also considered that the Doctor's assessment of S's head injury was inadequate because he had not demonstrated that he had considered whether she had amnesia or arranged for her to be observed, for a minimum of four hours, before discharging her. He was satisfied with the Health Board's management of the concussion issue.

The Ombudsman upheld Mrs T's complaint because he concluded that the Doctor had not assessed S properly. He recommended that the Health Board:

a) apologise to Mrs T

b) pay her a nominal sum of £200, and

c) provide training for relevant staff members and share his report with them.

The Health Board agreed to implement these recommendations.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital
Case reference 201501077 - Report issued in May 2016

Mr S complained about the care and treatment that his late father-in-law, Mr F, received following his admission to the Princess of Wales Hospital ("the Hospital") in January 2014 with a history of recurrent falls, lethargy, epileptic seizures, poor appetite, weight loss and bouts of confusion. Mr S complained that clinicians failed to ensure that Mr F received adequate fluids and food and failed to adequately manage and record Mr F's confused behaviour.

Mr S also complained that, despite Mr F's confused and vulnerable condition, he was taken to the Radiology Department for an X-ray by a hospital porter without a nurse escort. On arriving at the Radiology Department, the hospital porter briefly left Mr F unattended in his bed in the corridor in order to report his arrival to the Radiologist. During this brief interim, Mr F suffered a cardiac arrest. Mr F was resuscitated and transferred to intensive care, but, sadly, passed away a few days later.

The Ombudsman did not uphold Mr S's complaint that Mr F did not receive adequate fluids and food but upheld all of Mr S's other complaints. The Ombudsman concluded that, in accordance with Abertawe Bro Morgannwg University Health Board's ("the Health Board") Patient Escort Policy, Mr F should have been accompanied by a nurse (in addition to the porter). Whilst Mr F's cardiac arrest would not have been prevented by the presence of a nurse escort, it was fortuitous that Mr F's sudden deterioration was swiftly detected. The Ombudsman considered it an injustice to Mr F that he experienced the onset of a cardiac arrest while alone and without any reassurance that this had been noticed and that help would be forthcoming.

The Ombudsman recommended that the Health Board:

a) provide Mr S with a fulsome apology

b) make a payment to him in the sum of £500 in recognition of the identified failings and the inconvenience of pursuing a complaint about a matter which the Health Board might have acknowledged as a clear-cut service-failure earlier on in the process, and

c) ensure that clinicians are reminded of the provisions of the Escort Policy and of the requirement to assess, record and monitor the mental state/mental capacity of patients.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case reference 201401702 - Report issued in May 2016

Ms A complained about the standard of care provided to her late father in 2009. The complaint process had been ongoing since that time and the nature and length of this process formed a large part of the complaint. The Ombudsman found that Betsi Cadwaladr University Health Board's ("the Health Board") initial investigation of the complaint was poor. This had resulted in later delays and a lack of trust in the process. The Health Board subsequently investigated the complaint in 2012 and identified shortcomings in nursing care. Independent clinical advice obtained in 2013 found no failings in medical treatment.

The Ombudsman upheld the complaint about the handling of Ms A's complaint in that:

a) there were shortcomings in the complaints investigation and process

b) the identified shortcomings in nursing care had not been discussed with relevant nursing staff at any point

c) there were ongoing concerns about the quality of nursing care documentation and recording

d) there was no evidence of any learning from the complaint.

The Ombudsman made a number of recommendations. These included:

a) arrangements for effective complaints handling in line with its obligations under PTR

b) ensuring both localised and organisational learning from concerns and serious incidents

c) clarification that the Health Board's system for auditing the standard of clinical recording was robust

d) clarification about the availability of certain gastroenterology procedures (in particular ERCP) across the Health Board on an elective and emergency basis.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital
Case Reference 201500537 – Report issued in May 2016

Mrs F complained on behalf of her husband, Mr F, about his treatment and care at Morriston Hospital. ("the Hospital"). Mrs F was most concerned about the waiting time for Mr F's cardiac surgery. By the time of his surgery, Mr F had been admitted to Morriston Hospital as an emergency on two occasions

and his condition had deteriorated. He experienced significant post-operative complications of cardiac tamponade, breathing difficulties and bilateral vocal cord paralysis, prolonging his recovery.

Mrs F felt that earlier surgery was indicated at the time of the emergency admissions and that her husband would have "fared better" post-operatively had his surgery been brought forward. Mrs F also complained about poor communication and delays in relation to Mr F's later transfer to another hospital for specialist care.

The Ombudsman found that, given his changing symptoms, Mr F was not prioritised for surgery on the basis of his clinical need as he should have been. There were missed opportunities at a clinic appointment in March 2013, and during emergency admissions in April and May 2013, to expedite a surgical referral. The weeks of waiting between tests and appointments resulted in an excessive delay for a patient who was at high risk of a cardiac event.

By failing to take appropriate steps to prioritise his treatment, the Health Board also failed to minimise the risk of complications occurring. However, it was not possible to say definitively that the delay was directly causative of the complications Mr F went on to experience and the procedure itself appeared to have been successful in restoring his heart function to near normal. The investigation also identified some poor and inappropriate communication with Mr and Mrs F whilst he waited for a transfer to another hospital.

The Ombudsman recommended that the Health Board should:

(a) apologise to Mr F and Mrs F for the failings identified in the report

(b) make a payment to Mr F of £1000 in recognition of his overly delayed surgery and the unnecessary suffering and uncertainty caused to him and his family as a consequence

(c) ask the Cardiology Consultant to reflect on this case and identify any supervision needs in relation to the care of patients who present as an emergency with changing symptoms and who are awaiting treatment

(d) carry out a survey among the Cardiology clinicians to identify any barriers to obtaining urgent inpatient investigations

(e) at a documented meeting, remind the relevant nursing staff of the requirements of the NHS complaints procedure.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital
Case Reference 201500835 - Report issued in May 2016

Mrs C complained about the care and treatment provided to her son, D. In particular, she was concerned that despite deterioration in his health, a Consultant Paediatric Neurologist ("the Consultant") ignored her reports of pain and deterioration, failed to monitor and manage a clinical trial of Gabapentin recommended by a specialist hospital and did not arrange for a further pain referral despite it being requested.

Mrs C also complained that a meeting in March 2015 went ahead without her and that the Consultant had written incorrect and false information in a consultation letter about an appointment in April 2015. The Ombudsman found that the Consultant had taken Mrs C's concerns into account and carried out appropriate examinations. He also concluded that the trial of Gabapentin was carried out as intended.

In terms of a further pain referral, he found that there was no clinical indication for this and in any event, the Consultant had written to the specialist hospital for further advice. He found that whilst there were two minor inaccuracies in the clinic letter, these did not compromise D's care and were later addressed in the same letter. These complaints were not upheld.

He partially upheld the complaint relating to the March 2015 meeting. This was to the limited extent that, as a matter of good administration, when Mrs C left a message asking someone from the Health Board to contact her to discuss the meeting arrangements, there is no record that her call was returned or that confirmation was provided that the meeting was going ahead.

Hywel Dda University Health Board and a GP in the Hywel Dda University Health Board area – other
Case Reference 201501039 & 201501040 – Report issued in June 2016

Mr Y was terminally ill with heart failure. Miss X complained that both Hywel Dda University Health Board's ("the Health Board") District Nursing Services and the GPs at the Practice failed to put in place specific and appropriate palliative care arrangements for Mr Y, which resulted in him suffering a painful, distressing and undignified death.

The investigation found that there was service failure by both the Health Board and the Practice in the lack of planned provision of palliative care and support for Mr Y, lack of leadership in Mr Y's care, a lack of any robust system to monitor Mr Y's changing needs, and a failure overall to provide a holistic approach to his care. The service failures led to an injustice to Mr Y, and Miss X, as it caused unnecessary psychological distress for them both on the day Mr Y died, and Miss X remains concerned about whether the outcome may have been different had the appropriate palliative care, monitoring and pain relief been in place for Mr Y. Whilst Mr Y's eventual outcome may not have been different, his final days are likely to have been more peaceful and dignified which could have lessened the traumatic experience suffered by both Miss X and Mr Y on the day he died.

Miss X's complaint was upheld against both the Health Board, and the Practice. The Ombudsman recommended both the Health Board and the Practice should apologise to Miss X for the failings identified by the investigation, and each should pay her the sum of £1,000 and £2,000 respectively, in recognition of the distress and uncertainties caused by the shortcomings identified. In addition, appropriate recommendations were made to address the identified shortcomings in Mr Y's care.

A GP Practice in the Cwm Taf University Health Board area –Clinical treatment in hospital
Case Reference 201501651 – Report issued in June 2016

Miss W complained that the Practice had failed to recognise, diagnose and treat a skin infection to her lower left leg at three consultations in March 2015. Miss W considered that the Practice's failure to treat the infection caused it to develop into a serious ulceration resulting in a permanent scar.

The Ombudsman concluded that the first consultation was within acceptable clinical practice; however, the second and third consultations were not. The shortcomings identified amounted to service failure by

the Practice, which led to an injustice to Miss W by the unnecessary delay in the identification and start of her treatment (by seven days). Miss W's complaint was upheld to this extent.

The Ombudsman recommended that the Practice apologise and pay the sum of £750 to Miss W in recognition of the distress and uncertainties caused by the shortcomings identified. Further recommendations included consideration of national guidance for the management of skin wounds and a reminder about the need for comprehensive record keeping.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital
Case Reference 201501209 – Report issued in June 2016

Mr E complained that there was a lack of investigation and treatment of his late wife's falls over a number of years. The Ombudsman found that Abertawe Bro Morgannwg University Health Board 's ("the Health Board") actions fell short of good clinical practice and were contrary to relevant guidance. As Mrs E had multiple hospital attendances as a result of falls, she should have been referred to a specialist falls services to assess/investigate her falls. This may have resulted in interventions that could have prevented the falls and injuries Mrs E sustained as a result of these. The Ombudsman upheld Mr E's complaint.

A number of recommendations were made which included an apology for the identified failings and redress of £250 for the distress caused by these. The Ombudsman also recommended that Emergency Department ("ED") staff should be reminded of the importance of following the Health Board's community falls pathway for patients over 65 years old and that it should review ED arrangements to ensure that patients identified as at risk of falls are dealt with in line with relevant guidance. The Health Board agreed to implement the recommendations.

Cwm Taf University Health Board – Clinical treatment in hospital
Case Number: 201503626 – Report issued in June 2016

Mr X complained he had two circumcisions, on the first occasion too much foreskin had been left which led to phimosis (foreskin will not retract). After his second circumcision Mr X said too much skin had been removed, which had reduced his penis to half its original size, reduced his urine flow, caused stabbing pain in his urethra and the procedure had left him impotent.

The following aspects of the complaint were upheld:

- Mr X was overweight and diabetic, and the complication of developing a trapped penis had not been explained to him

- the relationship between Mr X and Cwm Taf University Health Board ("the Health Board") had deteriorated and it was unclear whether Mr X had been informed that he could access a neighbouring health board's consultant urologist.

The Ombudsman recommended the Health Board:

a) apologise to Mr X for not explaining to him the complication of developing a trapped penis

b) ensure Mr X was aware he could access a neighbouring health board's consultant urologist.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case Reference 201502644 – Report issued in June 2016

Mr N complained about the management and care his late father, Mr B, received in the days leading up to and including his death at Glan Clwyd Hospital ("the Hospital"). Mr B had a pre-existing abdominal aortic aneurysm (where a weakness in the artery wall causes bulging) which was being monitored. He had recently been diagnosed with terminal cancer. A post-mortem revealed that Mr B's aneurysm had ruptured leading to his death. Finally, Mr N expressed dissatisfaction with Betsi Cadwaladr University Health Board's ("the Health Board") handling of his complaint.

The Ombudsman having taken into account clinical advice concluded that even if a leaking aneurysm had been identified surgical intervention would not have been appropriate. The Ombudsman having found no significant failings in the management of Mr B's care did not upheld Mr N's complaint in respect of service failings.

The Ombudsman felt opportunities existed for clinicians to have communicated more effectively with Mr B and/or his family about the management of his aneurysm should it leak/rupture including the appropriateness of resuscitation. The Ombudsman also criticised record keeping by clinicians and the Health Board's handling of Mr N's complaint. He upheld these aspects of Mr N's complaint.

The Ombudsman recommended the Health Board apologise and pay £750 to Mr N for the failings as well as learn lessons from Mr B's case.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case Reference 201501506 – Report issued in June 2016

Miss X complained about the care and treatment that she received from the Urology Department at Glan Clwyd Hospital. ("the hospital") The complaint referred to substantial delays from 2012 in Miss X receiving surgery, diagnostic tests and follow up appointments for her kidney condition. Miss X also expressed concerns about Betsi Cadwaladr University Health Board's ("the Health Board") complaint response.

The Ombudsman found a catalogue of errors in Miss X's case. He said that it was unacceptable that 'urgent' appointments and surgery took so long to be actioned. He also found repeated failures in the booking of investigations and follow up appointments. The Ombudsman was critical of the access and communication arrangements within the Urology Department.

The Ombudsman, taking account of clinical advice, was of the view that there was clearly an injustice to Miss X. He said she suffered additional discomfort and distress as a result of the delays. The Ombudsman found that there was no direct evidence to suggest that there had been irreversible damage to Miss X's kidney. However, he said that unnecessary uncertainty had been created for Miss X. The Ombudsman upheld Miss X's complaint about her clinical care. The Ombudsman also found some shortcomings in the Health Board's complaint response and to the extent of these, upheld Miss X's complaint.

The Ombudsman recommended that the Health Board apologise and provide financial redress to Miss X of £2,750. He also recommended that the Health Board reviews its arrangements for managing bookings, and ensures the adequacy of administrative support and escalation procedures.

IDH My Dentist – Clinical treatment outside hospital
Case Reference 201503157 - Report issued in June 2016

Ms X complained about a Dental Practice in the area of Hywel Dda University Health Board. Ms X referred to having suffered unnecessary pain, having a poorly completed filling and said that her dental needs had not been adequately assessed.

Ms X also complained about the response provided to her complaint by the Dental Practice.
The Ombudsman took advice from one of his Dental Advisers and he found that there had been shortcomings in the dental care and treatment provided to Ms X.

The Ombudsman was of the view that there had been some injustice to Ms X particularly as her treatment should have been timelier and said that a degree of uncertainty, inconvenience and distress had been suffered by Ms X. To the extent of the identified shortcomings the Ombudsman upheld Ms X's complaints about her clinical care. He also upheld Ms X's concerns about the complaint response which she had received.

The Ombudsman recommended that the Dental Practice provide an apology and financial redress of £774 to Ms X and review its systems and processes.

Aneurin Bevan University Health Board – Clinical treatment in hospital
Case Reference 201505689 – Report issued in June 2016

Mrs X complained about the care and treatment her late husband, Mr X, received during an admission to hospital. Mrs X complained that Mr X was prescribed medication despite informing clinicians that he had an adverse reaction to it; that there was a failure to administer treatment to remove fluid from Mr X's lungs; there was a failure to monitor Mr X; that Mr X had been unnecessarily catheterised; and that there was a failure to complete medical records.

Mrs X also complained that Aneurin Bevan University Health Board ("the Health Board") failed to adequately respond to her complaint.

The investigation found that there was no evidence that the medication prescribed had an adverse effect on Mr X's condition and, unfortunately, despite medical intervention, Mr X deteriorated too quickly and sadly died. The investigation found no evidence to suggest that Mr X had been unnecessarily catheterised and the medical records were of a reasonable standard.

Finally, the investigation found that the Health Board had failed to provide Mrs X with a full response to her complaint. Instead, it provided a chronology of events.

It was recommended that the Health Board apologise to Mrs X for the failings identified and provide guidance to relevant officers on drafting meaningful complaint responses.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case Reference 201501306 – Report issued in June 2016

Mr C complained about the way in which Betsi Cadwaladr University Health Board ("the Health Board") treated his oesophageal achalasia ("OA"). He suggested that its response to his OA was unreasonably delayed, that it took too long to address his nutritional needs after his admission to hospital, that it pressurised him into having further dilatation , and that it failed to recognise that he was at increased risk of oesophageal perforation ("OP"). He also complained that its initial treatment of his OP was deficient.

The Ombudsman found that the Health Board took too long to type two key treatment-related letters. He partly upheld that aspect of Mr C's complaint, which concerned the Health Board's management of his OA, solely because of this administrative failing. He did not uphold that part of it, which was about the Health Board's initial response to his OP. The Ombudsman recommended that the Health Board should write to Mr C to apologise for the failing identified and take urgent action to address the administrative resource shortfall associated with it.

The Health Board agreed to implement these recommendations.

Hywel Dda University Health Board - Patient list issues
Case Reference 201501761 – Report issued in June 2016

Mr B complained to the Ombudsman that when Hywel Dda University Health Board ("the Health Board) placed him on its waiting list for a cataract operation, it gave him misleading information about the length of time he would have to wait for the procedure (three to five months when the actual waiting time was around twelve months). He also complained that the Health Board failed to respond to repeated queries about what alternative options were available for him to receive the cataract operation.

Mr B said that as a result of this lack of response from the Health Board about the options available to him he had no choice but to fund his cataract surgery himself.

Finally, Mr B complained that the Health Board took nine months to respond to his complaint despite a number of interventions by the Ombudsman.

The Ombudsman upheld all aspects of Mr B's complaints. He found that the Health Board had misled Mr B in terms of his likely waiting time for surgery and repeatedly failed to respond for his query about alternative options which gave Mr B little option than to fund the procedure himself. He also found that the complaint response had been delayed unreasonably and had failed to explain how it was dealing with his concern from the outset. The Ombudsman recommended that the Health Board provide £250, £2,000 and £500 for these failings respectively.

Hywel Dda University Health Board – Clinical treatment in hospital
Case Reference 201503319 – Report issued in June 2016

Mrs D complained that her father, Mr D, who had Parkinson's disease, had suffered a dislocation of his jaw whilst in Glangwili Hospital ("the Hospital) and that staff had failed to identify and treat the dislocation appropriately. She also complained about a delay in providing pain relief to her father once the dislocation was brought to their attention and that nursing staff had been rude to her when she raised concerns about the dislocation with them.

The Ombudsman found that missing Mr D's dislocation did not amount to a failure on the part of staff because of the relative difficulty in identifying it in Mr D's case. He also considered that the provision of pain relief had been appropriate once the dislocation had been identified. The Health Board acknowledged that staff had been "short" with Mrs D at the time and apologised to her and arranged for staff to receive training. Whilst the Ombudsman upheld this aspect of the complaint he found that no further action was necessary.

The Health Board had also implemented an action plan with a view to trying to reduce the likelihood of a recurrence. The Ombudsman found no failing with the care provided to Mr D although he invited the Health Board to undertake an audit of nursing records to ensure there is appropriate recording of any slips, trips or falls which was identified as a shortcoming during the investigation.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case Reference 201503891 – Report issued in June 2016

Mrs D complained to the Ombudsman about a delay in referring her for a second opinion to determine the cause of abdominal pain she had been experiencing over a three year period.

The Ombudsman found that the Betsi Cadwaladr University Health Board ("the Health Board") had acted appropriately to initially investigate the cause of Mrs D's pain. However, once these "frontline" investigations had been exhausted the Ombudsman considered that the Health Board should have considered arranging for Mrs D to receive a second opinion. Whilst the referral was eventually made to another Health Trust, the Ombudsman considered there had been a delay of 15 months in arranging this.

He upheld the complaint and recommended that the Health Board apologise to Mrs D and pay her redress of £500. He also recommended that the Health Board review its referral pathways for patients to upper gastrointestinal specialist centres and that it strengthen its mechanisms for discussing patients at MDT meetings.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case Reference 201501827 – Report issued in June 2016

Mrs X complained about the care and treatment her father, Mr Y, received during his admission to Ysbyty Alltwen (the hospital") between 15 December 2011 and 13 January 2012. In particular, she questioned why Mr Y did not receive anti-sickness injections as a preventative measure. Mrs X also complained that adequate records of Mr Y's food and fluid intake had not been kept at all times and a bone scan was not ordered for Mr Y.

Mrs X also said that the family were not kept adequately informed as to Mr Y's condition. Mrs X complained that Mr Y was not transferred to Ysbyty Gwynedd between 15 - 21 December. She complained that adequate records were not kept about Mr Y's fall on 11 January 2012. Mrs X complained about the handling of her complaint.

The Ombudsman found that Mr Y did receive anti-sickness injections appropriately. He found that adequate records were not kept of Mr Y's food and fluid intake and therefore upheld the complaint. A bone scan had been ordered for Mr Y. The Ombudsman found that there had been adequate communication with the family regarding Mr X's condition. The Ombudsman found that adequate

medical records had not been kept of Mr Y's fall, although the nursing records made were reasonable, and partly upheld the complaint. The Ombudsman also upheld Mrs X's complaint about a delayed complaint response.

The Ombudsman made a number of recommendations, including an apology to Mrs X for the identified failings. He recommended a payment of £250 in respect of the delayed complaint response. He also recommended that relevant nursing and medical staff be reminded of the importance of record keeping.

NOT UPHELD

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital
Case reference 201500785 – Report issued in April 2016

Mr D complained about the care and treatment he received from Abertawe Bro Morgannwg University Health Board ("the Health Board") between 2007 and 2014.

The specific complaints the Ombudsman investigated were that:

a) the Health Board failed to appropriately manage Mr D's complaint
b) the Health Board failed to treat Mr D's open wound within a reasonable length of time
c) the Health Board failed to adequately manage Mr D's heart condition
d) the Health Board failed to adequately assess and treat Mr D's back pain, and
e) Mr D was inappropriately discharged from the Princess of Wales Hospital on 15 April 2013.

With regard to the first complaint, during the course of the investigation the Health Board acknowledged that there was a delay in responding to Mr D's complaint. It offered Mr D an apology and a payment of £250 in recognition of this. Consequently, the Ombudsman considered this element of the complaint to be settled.

With regard to Mr D's second complaint the Ombudsman found that, although the Health Board failed to meet its Referral to Treatment Target (RTT) by two weeks, this was justified under the circumstances as Mr D required cardiac treatment which meant that he was unsuitable for surgery.
With regard to Mr D's third complaint, the Ombudsman found that Mr D's cardiology care was appropriate and in line with relevant guidance.

With regard to Mr D's fourth complaint, the Ombudsman found some failings during Mr D's assessment, in particular, that the Health Board should have considered undertaking an MRI scan. However, a later MRI scan confirmed that Mr D did not require surgery. That being so, the Ombudsman was of the view that this did not appear to have caused Mr D any additional harm. Finally, there was no evidence to suggest that the management of Mr D's discharge from the Hospital was unsafe. Therefore the Ombudsman did not uphold the complaint.

Cwm Taf University Health Board - Clinical treatment in hospital
Case reference 201503562 – Report issued in April 2016

Mrs K complained about several aspects of the standard of care provided to her late mother, Mrs J at Ysbyty Cwm Rhondda in 2014. The Ombudsman obtained clinical advice on the complaint. He found that there were no shortcomings in the management of Mrs J's medication or condition. There was

no additional treatment that could have been offered to her. The Ombudsman did not uphold the complaint.

However, he noted that some of the recording by one clinician (who had since retired) was poor and lacked detail. Cwm Taf University Health Board ("the Health Board") had also previously apologised to Mrs K that the fluid balance charts had not been completed to an acceptable standard.

The Ombudsman suggested that the Health Board should consider the following points:

a) how clinical cover is provided on the relevant wards to ensure that patients are regularly reviewed

b) how to ensure that a good standard of nursing and medical record keeping is maintained (by having an effective audit system), and

c) how to promote effective communication with patients and relatives by both medical and nursing staff about a patient's condition and treatment.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201504401 – Report issued in April 2016

Mr X complained about the failure to take a lymph node biopsy in respect of his late wife, Mrs X. He said such a biopsy would have given a more accurate diagnosis of her illness and its poor prognosis. He said she was denied the opportunity to elect for palliative treatment from the outset instead of the aggressive chemotherapy she underwent.

The Ombudsman found that a lymph node biopsy was not indicated, would not have provided any additional information and would not have altered Mrs X's treatment plan. The Ombudsman concluded that the care Mrs X received in this respect was appropriate and did not uphold the complaint.

Abertawe Bro Morgannwg University Health Board – Continuing Care
Case reference 201501762 – Report issued in April 2016

Mr Z complained about Abertawe Bro Morgannwg University Health Board ("the Health Board"), and the Independent Review Panel's ("IRP") consideration and decision about his retrospective claim for NHS funded healthcare ("CHC") for his late mother.

The Ombudsman's investigation found that the Health Board and the IRP had followed the procedure set out in the Welsh Government guidance; had considered all the available evidence; and had applied the relevant tests in reaching the decision that his late mother was not eligible for CHC.
The Ombudsman did not uphold Mr Z's complaint.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case reference 201504386 - Report issued in May 2016

Miss A complained about the treatment her late mother, Mrs B, received for her cardiac condition from January 2013. Mrs B sadly died in October 2014. In particular, Miss A complained that an angioplasty was not offered sooner and that by the time Mrs B did have an angioplasty her condition had deteriorated so much that it was ineffective. Miss A also complained about delays in Betsi Cadwaladr University Health Board's ("the Health Board") response to her complaint.

The Ombudsman found that Mrs B's condition was appropriately treated, although communication regarding treatment options could have been better. He found that the Health Board had offered apologies for its poor complaint handling. The Ombudsman did not uphold the complaints.

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201505559 - Report issued in May 2016

Miss F complained about the treatment she received at the Gynaecology Department of Cardiff and Vale University Health Board ("the Health Board"), between 21 October and 14 November 2014, following a termination of pregnancy.

Miss F underwent a termination of pregnancy on 22 October 2014 and completed the procedure on 24 October. Following this, Miss F suffered heavy vaginal bleeding. She attended the Hospital's Emergency Department on two occasions prior to being transferred to the Hospital by ambulance on 14 November. She underwent an emergency procedure to remove pregnancy tissue from the womb and required four units of blood transfused.

It was found that Miss F experienced an unfortunate complication of pregnancy termination, which was managed appropriately by the Health Board. As such, the complaint was not upheld and no recommendations were made.

Powys Teaching Health Board - Continuing care
Case Reference 201502081 – Report issued in May 2016

A firm of solicitors made a complaint about the decision that had been made in respect of eligibility for NHS Funded Continuing Care (NHSFCC) for Mrs X. The legal representative said that the primary health need approach was not properly considered. He also said that the evidence supported NHSFCC eligibility (particularly from 8 December 2002 to 18 June 2003). The legal representative also complained about the lack of entitlement to an Independent Review Panel (IRP).

Taking account of clinical advice, the Ombudsman was of the view that a reasonable assessment had been carried out in Mrs X's case and said that the correct approach had been adopted.

The Ombudsman found that Mrs X's claim for retrospective NHSFCC had been managed in line with the relevant Welsh Government guidance. He also said that the Health Board had been reasonable in not identifying an 'element of doubt'. In this circumstance, the Ombudsman said there was nothing to suggest that an IRP should have been held. The Ombudsman did not uphold the complaint.

Hywel Dda University Health Board & Pembrokeshire County Council - Other
Case Reference 201502572 & 201504680 – Report issued in June 2016

Mr Y complained about the care his wife received during the short period she lived at a care home, resulting in a deterioration in her condition and the need for her to be admitted to hospital. Mrs Y's care was funded partly by the Council and partly by the Health Board.

The Ombudsman found nothing to suggest that Mrs Y's deterioration was as a result of any lack of care on the part of the care home. He did not uphold the complaint.

Aneurin Bevan University Health Board – Clinical treatment in hospital
Case Reference 201500269 – Report issued in June 2016

Mr X complained that, despite being seen by numerous clinicians, they were not able to establish that he might be suffering from sleep apnoea (the absence of breathing during sleep despite continuing respiratory effort) and refer him to the correct department, meaning he was left to suffer with the symptoms untreated for a number of years.

The investigation found that while sleep apnoea could have been investigated and diagnosed sooner than it was, the delay in diagnosing Mr X's condition was not as a result of an unreasonable standard of care on the part of the clinicians involved in his case. The complaint was therefore not upheld.

Abertawe Bro Morgannwg University Health Board –Clinical treatment in hospital
Case Reference -201501027 - Report issued in June 2016

Mrs X complained about a failure to provide adequate/timely pain relief during child birth. The Ombudsman found that she did not receive ideal care but in the circumstances at the time, the care did not amount to service failure. The complaint was not upheld.

EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

Powys Teaching Health Board – Continuing Care
Case reference 201506835 – Report issued in April 2016

Mrs A complained about shortcomings in the process which had taken place in respect of the consideration of her late mother's (Mrs B) eligibility for NHS Funded Continuing Care. She was particularly concerned that an Independent Review Panel (IRP) went ahead without the relevant Clinical Advisor being present. She noted that the IRP did not have an opportunity to discuss significant questions raised with the Advisor and consider the rationale behind her earlier decision making. Mrs A highlighted that the changes made at the negotiation meeting could not be satisfactorily considered by the IRP.

A settlement was reached in this case as Powys Teaching Health Board agreed to arrange for a newly constituted IRP to consider Mrs B's case with the relevant Clinical Advisor being in attendance. It also agreed to apologise to Mrs A for this being a necessary outcome.

Hywel Dda University Health Board – Clinical treatment in hospital
Case reference 201506695 – Report issued in April 2016

Mrs X complained about the delays encountered with Hywel Dda University Health Board ("the Health Board") in responding to her concerns regarding the treatment of her late father.

The Ombudsman advised Mrs X that investigations by a Health Board regarding concerns of a very sensitive and serious nature may take longer than initially expected but that it was recognised that, in a letter dated 5 January 2016, the Health Board advised that its investigations were nearing completion and a response was imminent.

Concerns were therefore expressed to the Health Board that, three months following that letter, a response had still not been received. It therefore agreed to write to Mrs X with a full response within ten working days.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case reference 201507146 – report issued in April 2016

Miss A complained to the Ombudsman that she made a complaint to Betsi Cadwaladr University Health Board ("the Health Board") in November 2015; however it had failed to respond.

After contacting the Health Board the Ombudsman established that an offer of a meeting was made to Miss A to discuss her concerns; however Miss A declined this. The Health Board failed to follow up in writing.

Therefore the Ombudsman asked the Health Board to:

a) expedite an investigation and respond to Miss A as soon as possible, and

b) offer Miss A a payment of £100 for failure to respond to the complaint with a letter of apology while she is awaiting the response.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201506559 – Report issued in April 2016

Mr B complained to the Ombudsman about Betsi Cadwaladr University Health Board's ("the Health Board") delay in responding to a complaint submitted under the Putting Things Right process.

Mr B had expressed concerns about the care and treatment afforded to a close family member whilst in hospital. The Ombudsman contacted the Health Board to discuss the complaint and they agreed to the following recommendations:

a) expedite its final response to Mr B

b) to provide the response within three weeks, and

c) to apologise for delay.

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case reference 201600073 - Report issued in April 2016

Mr X complained that he was yet to receive a comprehensive final response after making a complaint to Aneurin Bevan University Health Board ("the Health Board") in December 2015.

On receipt of the complaint, the Ombudsman contacted the Health Board which agreed to provide its response at the earliest possible date. The response has since been issued.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201506940 - Report issued in April 2016

Mrs X complained to the Ombudsman that Betsi Cadwaladr University Health Board ("the Health Board") had failed to meet its six week target to provide a response to all outstanding issues. Mrs X had initially complained to the Health Board in June 2014.

The Ombudsman contacted the Health Board to discuss the complaint and they agreed to the following

recommendations:

a) to apologise for the current delay and provide an update

b) to expedite its full response

c) to pay Mrs X the sum of £50 in recognition of the ongoing delay.

Cwm Taf University Health Board - Clinical treatment in hospital
Case reference 201506542 - Report issued in April 2016

Mrs D complained about the standard of care and treatment that her father received whilst he was a patient at the Royal Glamorgan Hospital. Mrs D complained to Cwm Taf University Health Board ("the Health Board") in April 2015, and received the Health Board's response by letter dated 30 September 2015. However, Mrs D complained that she was struggling to get a full picture of the care given to her father, and there were voids in the time frame for which she had not received an explanation from the Health Board.

On receipt of the complaint, the Ombudsman considered that it would be helpful for Mrs D to meet with the Health Board to discuss the outstanding issues. Following a discussion with the Health Board, it agreed to contact Mrs D directly within two weeks from the date of the decision letter being issued in order to arrange a convenient date when Mrs D could meet with the Health Board.

Betsi Cadwaladr University Health Board - Clinical treament in hospital
Case reference 201506987 - Report issued in April 2016

Mr A first complained to the Ombudsman in February 2016 because he had not received a response to a complaint made in October 2015 about his care and treatment. At that time Betsi Cadwaladr University Health Board ("the Health Board") gave an undertaking to respond to Mr A in full. Six weeks later, Mr A subsequently contacted the Ombudsman to complain that he had still not received the response.

The Health Board agreed to the following recommendations:

a) to expedite the completion of its full response, and

b) to pay Mr A the sum of £50 in recognition of the distress caused by the delay

Hywel Dda University Health Board – Clinical treatment in hospital
Case reference 201506276 - Report issued in April 2016

Ms X complained that after submitting a complaint to Hywel Dda University Health Board ("the Health Board"), concerning the care and treatment provided to her late father, there was a meeting in November 2015 where some of her concerns were addressed but not all of them. However, at the time of submitting her complaint to the Ombudsman she had still not received a copy of the meeting minutes.

On receipt of her complaint, the Ombudsman contacted the Health Board which agreed to send Mrs X a copy of the meeting minutes together with an apology. Ms X was advised that if the meeting minutes did not materialise or if she was not satisfied with the contents of them or how the Health Board had dealt with her complaint she could come back to the Ombudsman.

Aneurin Bevan University Health Board – Clinical treatment in hospital
Case reference 201506750 - Report issued in April 2016

Mr A complained to the Ombudsman that he was not notified of biopsy results, despite numerous attempts to contact the department, and then had to wait for a follow-up appointment. Mr A also said that when he complained to Aneurin Bevan University Health Board ("the Health Board") it was not clear who was his point of contact and the two members of staff he dealt with did not keep in contact regularly, or progress the complaint in a timely manner.

The Ombudsman found that communication was unclear and inconsistent, and there were protracted periods where the Health Board failed to make contact with the complainant. The investigation further found that the Health Board failed to adhere to the Putting Things Right policy in terms of keeping the complainant informed and managing his expectations.

The Ombudsman recommended the following actions which the Health Board agreed to:

a) a full apology for the failures in communication and complaint handling

b) a sum of £250 offered to reflect the time, trouble and additional distress.

Betsi Cadwaladr University Health Board - Appointments/admissions/discharge and transfer procedures
Case reference 201504737 - Report issued in April 2016

Mrs A complained to the Ombudsman about Betsi Cadwaladr University Health Board's ("the Health Board") decision to allow her son to go home from hospital over the Christmas period. Mrs A said the decision was inappropriate because there was an ongoing Protection Of Vulnerable Adults (POVA) investigation concerning an allegation of harm caused by another resident at the care home where he lived.

On receipt of the complaint, the Ombudsman contact the Health Board and it agreed to liaise with Conwy County Borough Council to conduct a joint investigation to consider whether the potential ongoing risk to Mrs A's son was appropriately managed during the course of the POVA investigation.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital
Case reference 201506561 - Report issued in April 2016

Mrs X complained to the Ombudsman about her late husband's treatment and care and the circumstances of his death at the Princess of Wales Hospital on 11 November 2014. Mr X's medical records had been mislaid by Abertawe Bro Morgannwg University Health Board ("the Health Board") and the Ombudsman was not able to carry out an independent investigation of Mrs X's concerns.

The Ombudsman contacted the Health Board and proposed that there was further action it could take in settlement of the complaint and it agreed to undertake the following:

a) continue to actively search for the medical records

b) if, after the period of one month, the records have failed to materialise, apologise in writing to Mrs X and make a payment to her of £1750 in recognition of the injustice caused by not being able to have

her complaint independently investigated.

c) make an additional payment to Mrs X of £750, in recognition of the significant and ongoing distress caused by the acknowledged failure to lay her husband's body out in a respectful and fitting manner and her witnessed dispute between a doctor and nurse about the circumstances of his death.

d) within two months of the date of this decision, carry out a root cause analysis of the loss of the records.

e) continue to actively search for the medical records for a period of six months and provide a final update to Mrs X, explaining the action taken to locate the records and the outcome of the root cause analysis.

Hywel Dda University Health Board – Clinical treatment in hospital
Case reference 201505770 - Report issued in April 2016

After a complaint was submitted to Hywel Dda University Health Board ("the Health Board") on 25 November 2014, Mrs X complained to the Ombudsman that Hywel Dda University Health Board's ("the Health Board") final response remained outstanding.

On receipt of the complaint the Ombudsman contacted the Health Board which agreed to the following:
a) provide both Mrs X and her advocate at the Community Health Council with an apology and full reasons for the delay in responding to the complaint

b) provide Mrs X with a payment of £500 in recognition of the time and trouble in having to bring the complaint to the Ombudsman, the Health Board's failure to provide meaningful updates to both Mrs X and her advocate and the delay in providing a response.

Betsi Cadwaladr University Health Board – Continuing Care
Case Reference 201600348 - Report issued in May 2016

In January 2016 Mr C complained to Betsi Cadwaladr University Health Board ("the Health Board) about its decision to not review, re-calculate and pay a different level of interest rate in relation to a previously settled Continuing Health Care case. Mr C was also unhappy that he had gone to a considerable amount of time and effort to gather together personal financial documentation over a period of six months. Mr C then approached the Ombudsman as he was unhappy at why it had refused his application.

On receipt and assessment of the complaint, the Ombudsman found that whilst it was reasonable to refuse Mr C's application, the Health Board had in fact raised Mr C's expectations by suggesting it would re-calculate the interest rate.

The Ombudsman contacted the Health Board and it agreed to resolve the complaint on the following basis:

1. to write a letter of apology for unnecessarily raising Mr C's expectations, and

2. make a payment to Mr C of £250 in recognition of the time and trouble in retrieving documentation over a six month period.

Aneurin Bevan University Health Board – Clinical treatment in hospital
Case Reference 201600160 – Report issued in May 2016

Mrs P complained that the treatment her sister received was substandard, which resulted in her deterioration and subsequent death. Mrs P raised concerns regarding the provision of medication and pain relief as well as staff approach and attitude. Mrs P further complained that Aneurin Bevan University Health Board ("the Health Board") had failed to provide a response to your concerns within a reasonable time period.

The investigation found that although the Health Board had intended to provide a response, Mrs P had been awaiting the conclusion of the investigation for six months, which is outside of the Ombudsman's guidelines. The investigation also found that until the Health Board had concluded their report, no determination could be made as to whether any maladministration or service failure had taken place in terms of patient care.

The Ombudsman therefore recommended the following actions to be undertaken:

(a) an apology be given for the significant delays in response time

(b) an offer of £100 financial redress be made

(c) the investigation to be concluded and the final response expedited.

IDH My Dentist – Other
Case Reference 201600933 – Report issued in May 2016

Mr W initially complained to Hywel Dda University Health Board ("the Health Board") in November 2014 about the treatment he had received at Robert Street Dental Practice. The Health Board passed the complaint to the Dental Practice which responded to Mr W on 13 April 2015. Mr W was unhappy with the response, therefore he wrote a further letter to the Health Board on 23 April 2015, detailing his outstanding concerns about the dental treatment he received.

On receipt of the complaint, the Ombudsman noted that the Dental Practice had not had not seen a copy of Mr W's further letter to the Health Board, therefore it was not aware of his outstanding concerns.

The Ombudsman contacted the Dental Practice to discuss Mr W's concerns and it agreed to provide a written response to the concerns as outlined in Mr W's letter to the Health Board by 7 July 2016.

Cwm Taf University Health Board - Clinical treatment in hospital
Case Reference 201600808 – Report issued in May 2016

Mr A raised a complaint about the length of time it had taken Cwm Taf University Health Board ("the Health Board") to consider a complaint about care and treatment he received whilst a patient at Prince Charles Hospital. Mr A made a complaint in April 2015 however had not yet received a response.

The Health Board confirmed that this complaint was a complex case and an update letter had been recently sent explaining the Health Board's position.

The Health Board agreed to offer Mr A a payment of £100 for the delay in the complaint process.

Hywel Dda University Health Board - Clinical treatment in hospital
Case Reference 201600813 – Report issued in May 2016

Mrs A complained that Hywel Dda University Health Board ("the Health Board") had failed to recognise or take seriously a gynaecological issue that had resulted in her and her husband being unable to naturally have children. Mrs A complained about the length of time that had elapsed for an operation which could have been avoided. Mrs A said she felt let down by both the GP and Hospital.

On receipt of the complaint, the Ombudsman contacted the Health Board to establish its position in considering the complaint and whether a response to the concerns raised in July 2015 was near completion. The Health Board responded and informed the Ombudsman that a response was nearly complete.

The Health Board agreed to:

(a) provide an apology for the continued delay

(b) offer Mrs A a payment of £100 for the time and trouble in having to bring a complaint and the delay in the Health Board responded to the concerns raised, and

(c) provide Mrs A with a response to her concerns by 31 May 2016.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital
Case Reference 201503893 Report issued in May 2016

Ms A complained on behalf of her son about the care and treatment that her son received following a sports related injury to his left knee in 2014. From a complaint handling perspective, Mrs A also complained about the communication difficulties that she encountered, particularly in the period following her son's operation.

As Ms A's son had decided to go down the route of legal action the Ombudsman discontinued his investigation into the clinical aspect of the complaint.

The Ombudsman reached a settlement with the Health Board on the complaint handling aspect of Ms A's complaint. The terms of the settlement was that the Heath Board should make a payment of £250 for the inconvenience and difficulties caused by the shortcomings in communication.

Cardiff and Vale University LHB - Clinical treatment in hospital
Case reference 201600947 – report issued in June 2016

Mr A complained that whilst he was admitted to the University Hospital of Wales in June 2013 he contracted Hepatitis C. Although this matter was subject of an internal investigation by Cardiff and Vale University Health Board ("the Health Board") it was unable to identify the source of infection. Mr A expressed concern that the Health Board had failed to take accountability. Further Mr A complained about the length of time taken by the Health Board to investigate the matter and provide a report of its findings.

Having considered the complaint the Ombudsman found that although the Health Board's internal investigation had been extensive, sadly, it had failed to conclusively identify the source of the infection. It

was felt that little further could be achieved through an investigation of Mr B's complaint.

However on receipt of the complaint, the Ombudsman contacted the Health Board and it accepted that there had been an unreasonable delay in providing Mr A with a copy of the investigation report. In recognition of this the Health Board agreed to:

a) apologise to Mr A

b) pay £250 to Mr A for the time and trouble taken to pursue his complaint

c) ensure that internal investigations are completed in line with the Putting Things Right regulations and timelines.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case reference 201601048 - Report issued in June 2016

Mr M complained about the care and treatment provided to his father and requested a full investigation into Betsi Cadwaladr University Health Board's ("the Health Board") role in the events leading up to his death. The Health Board provided an initial response regarding the short time Mr M's father was under its care. However, following a further complaint from Mr M, the Health Board deemed a review was warranted and conducted a second investigation.

The Ombudsman found that the second investigation was reasonable and appropriate and the Health Board demonstrated a reasonable standard of care. However, the consequence of the review meant a subsequent delay of 5 months for Mr M to receive a full and final response.

Therefore the Health Board agreed to provide a written apology to Mr M for the inconvenience in having to raise further concerns to prompt a more complete investigation and the delay in issuing an ultimate response.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital
Case reference 201600304 - Report issued in June 2016

Mrs X complained about her late husband's treatment and care and the circumstances of his death at the Princess of Wales Hospital on 11 November 2014. At the time of the complaint to the Ombudsman, Mr X's medical records had been mislaid by Abertawe Bro Morgannwg University Health Board ("the Health Board") and it had not been able to respond fully to the concerns Mrs X had raised. The Health Board continued its search for the records and they were located. In view of this, the Ombudsman asked the Health Board, and it agreed, to undertake the following in settlement of the complaint:

a) provide Mrs X with an explanation for the loss of her husband's medical records and any measures taken to ensure that this does not happen again

b) expedite a full complaint response to Mrs X

c) apologise to Mrs X and pay her £250 in recognition of the delay and continuing doubt over Mr X's treatment and care caused by the loss of the records.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201600226 - Report issued in June 2016

Mrs G raised an informal complaint with Betsi Cadwaladr University Health Board ("the Health Board") on 4 August 2014, regarding the treatment she received at the Emergency Department at Wrexham Maelor Hospital, following her attendance on 23 May 2014. Mrs G met with representatives to discuss her concerns but felt that the meeting was unsatisfactory and lacked explanation. Mrs G therefore wrote a formal complaint letter to the Health Board on 1 June 2015 but following its response Mrs G was unhappy.

Mrs G wrote a further letter to the Health Board expressing her disappointment and the Health Board provided its final response on 7 March 2016. Mrs G complained to the Ombudsman about the length of time taken by the Health Board to deal with her complaint.

The Ombudsman concluded that there was some delay by the Health Board in dealing with the complaint, and the Health Board had failed to keep Mrs G properly informed about the progress made during the course of its investigation.

The Health Board accepted that the investigation took longer than anticipated and that it could have made more attempts to keep Mrs G informed during its investigation. The Health Board agreed to undertake the following action in settlement of Mrs G's complaint:

a) to provide Mrs G with a written apology for the delay in dealing with her complaint

b) to make an offer of £150.00 in recognition of the distress caused to Mrs G as a result of the delay.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201601189 - Report issued in June 2016

Mrs F complained that she had raised concerns with Betsi Cadwaladr University Health Board ("the Health Board") in December 2015 but it had only responded to one aspect of her complaint. The Ombudsman found that Mrs F had made two separate complaints which were acknowledged, but the Health Board failed to progress the second complaint appropriately or provide a response to it.

The Health Board agreed to undertake the following action in resolution of this complaint:

a) expedite an investigation into Mrs F's clinical concerns and provide a full response within 8 weeks of the Ombudsman's final notification

b) apologise in writing for the complaints handling failure and offer a sum of £250 redress within 4 weeks of the Ombudsman's final notification.

Cwm Taf University Health Board - Clinical treatment in hospital
Case reference 201600811 - Report issued in June 2016

A firm of solicitors ("the solicitors") complained about Cwm Taf University Health Board's ("the Health Board") delay in dealing with a complaint submitted by their client, Mrs D and lack of progress. The complaint centred on her mother's clinical care and was submitted in April 2013. In 2015, the Health Board agreed the complaint should proceed through the Redress provisions of the "Putting Things Right

(PTR)" Regulations and to jointly instruct an independent expert in accordance with the PTR provisions. After agreement with the solicitors on the expert the Health Board informed them in December 2015 that it would prepare draft instructions for their approval, and that the expert could give his opinion within 4-6 weeks. The solicitors had heard nothing further by 9 May 2016 when they complained to the Ombudsman.

Having considered the papers submitted to him, the Ombudsman took the decision to seek the Health Board's agreement to resolve the complaint, in accordance with his powers. The Health Board agreed to implement the following actions in full:

a) send the draft joint letter of instruction to the solicitors for approval within 10 working days

b) despatch it to the expert within 7 working days of the solicitors agreeing the draft

c) apologise in writing to Mrs D for the complaint handling failures and ongoing delay (within 20 working days)

d) offer Mrs D redress of £400 for those complaint handling delays.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case reference 201600848 - Report issued in June 2016

A firm of solicitors ("the solicitors") complained about the way in which Betsi Cadwaladr University Health Board ("the Health Board") had dealt with a complaint submitted by their client, Mrs A about the care of her late husband, Mr A. They complained to the Ombudsman that the Health Board was failing to comply with the process set down in the Redress provisions of the "Putting Things Right" (PTR) Regulations.

Whilst the Health Board had acknowledged in correspondence that there was a breach of duty relating to Mr A's care, for a small period of time, and so a possible qualifying liability which might lead to redress, it had not agreed to the solicitors' request to jointly instruct an independent expert to assess the care.

In looking at the provisions of the PTR Regulations, the Ombudsman noted that where the Health Board had indicated there may be a qualifying liability; those provisions said that it must proceed to a joint expert instruction. Having considered the papers submitted to him, the Ombudsman took the decision to seek the Health Board's agreement to resolve the complaint, in accordance with his powers. The Health Board agreed to implement the following actions in full:

a) issue a written apology to Mrs A for its complaint handling failure in this case (within one month)

b) communicate with the solicitors within 14 working days to agree the appointment of a joint expert and progress the matter under Part 6 of PTR with due diligence thereafter.

Hywel Dda University Health Board – Clinical treatment in hospital
Case reference 201601041 - Report issued in June 2016

Ms T complained that when she attended Accident and Emergency, Hywel Dda University Health Board ("the Health Board") failed to diagnose her fractured knee. When Ms T returned for a follow-up appointment, she was informed that there was a fracture, and referred for an MRI scan and subsequent surgery. Ms T also complained that although she had received an acknowledgement, she had waited

seven months for a full response.
The Ombudsman requested that the Health Board undertake to provide Ms T with an apology and explanation for the delay, and a timescale within which she could expect a response.

The Health Board issued:

a) a full response to the complaint

b) an apology for the delay

c) details of further action in consideration of qualifying liability

A GP in the Betsi Cadwaladr University Health Board area- Other
Case reference 201600748 - Report issued in June 2016

Mr X complained that his son, who was on holiday in Wales from Malta, was charged for a doctor's appointment and a prescription when he fell ill and attended the local Practice. He complained that his son should not have been charged as he had a valid European Health Insurance Card (EHIC) and that the treatment he needed met the Health Board's Overseas Visitor's Guidance of being 'medically necessary'.

The Ombudsman found that the Health Board guidance included Malta as one of the countries in the European Economic Area where an overseas visitor, with a valid EHIC card, would not need to pay for any 'medically necessary' treatment during a visit to the Betsi Cadwaladr area.

Whilst the Ombudsman did not make a recommendation in relation to the prescription charge, he was satisfied that Mr X's son met the Overseas Visitor's criteria and that his appointment was 'medically necessary'. Therefore, he recommended the following settlement that the Practice agreed to undertake:

a) send Mr X a cheque for £55 on 10 June 2016 as a refund for the appointment his grandson paid for at the Practice in December 2015

b) apologise for the inconvenience caused to Mr X in making this complaint

Aneurin Bevan University Health Board – Clinical treatment in hospital
Case Reference 201504372 – Report issued in June 2016

Mrs P complained about her management and care following an early miscarriage. She was also unhappy that she had not been kept updated about any changes that Aneurin Bevan University Health Board ("the Health Board") had introduced as a result of her complaint.

The Ombudsman's investigation confirmed that there had been shortcomings in communication on the part of the Health Board, although he identified that the Health Board had taken steps to address those shortcomings including providing training and making changes to its patient information leaflets.

The Health Board agreed to the additional recommendations that the Ombudsman proposed by way of settlement. These included the Health Board making a further apology, meeting with Mrs P to enable her to feedback her experiences/suggestions as well as providing input into a patient survey. The Ombudsman also made recommendations which focused on training and learning opportunities for clinicians.

Hywel Dda University Health Board - Appointments/admissions/discharge and transfer procedures
Case Reference 201507159 – Report issued in June 2016

Mr X complained that Hywel Dda University Health Board ("the Health Board") did not consider his clinical need when assessing his need for surgery. Mr X also complained that the Health Board failed to adequately respond to his complaint in accordance with the "putting things right" process.

In response to the complaint the Health Board accepted that there had been some delays and it was agreed that a settlement could be reached to resolve the complaint to the satisfaction of the Ombudsman.
It was agreed that within one month, the Health Board would:

(a) apologise to Mr X for the delays he had experienced

(b) meet with Mr X to discuss his concerns further, provide an explanation for the delays and agree an appropriate figure of redress.

Complaints handling

EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

Powys County Council - Housing
Case reference 201505489 - Report issued in April 2016

In December 2014 Mrs C complained to Powys County Council ("the Council") about the height of her neighbour's hedge. The Council took one year to respond to her complaint when it had indicated it would take 12 weeks. Mrs C then complained to the Ombudsman that she was unhappy at the time taken to respond and the reasons for rejecting her complaint.

On receipt and assessment of the complaint, the Ombudsman contacted the Council to discuss Mrs C's concerns. The Council agreed to resolve the complaint on the following basis:

a) to apologise for the significant delay in respect of providing a response

b) to make a payment of £150 by way of an apology in recognition of the delay in responding, and

c) to visit Mrs C and provide a full explanation as to why her complaint was rejected.

Aneurin Bevan University Health Board - Health
Case reference 201506314 - Report issued in April 2016

Mr X complained to the Ombudsman that after making his original complaint to Aneurin Bevan University Health Board ("the Health Board") in October 2015, he was still awaiting the Health Board's final response. Mr X also complained that he had also not been sufficiently updated by the Health Board on the progress of the complaint.

On receipt of the complaint, the Ombudsman contacted the Health Board which agreed to provide Mr X with the final response to the complaint.

Cardiff and Vale University University Health Board - Health
Case reference 201507148 - Report issued in April 2016

Mr X complained to the Ombudsman that he had not yet received a response to a complaint made about his treatment in December 2015. Cardiff and Vale University Health Board explained that the delay was due to the complex nature of Mr X's complaint, but confirmed that:

b) a review had now been arranged with the various clinical teams involved, and

c) a written response would be issued within the next seven working days.

Betsi Cadwaladr University Health Board - Health
Case reference 201600136 - Report issued in April 2016
Ms T complained to the Ombudsman on behalf of Mr X about the time it took for Betsi Cadwaladr University Health Board ("the Health Board") to respond to a complaint about treatment for his bowel problems. Ms T made further written representations that month but the Health Board had not responded. Mr X was concerned that the delay might interfere with their right to take legal action.

The Health Board agreed to:

a) issue a response as soon as possible, and
b) apologise for the delay.

Betsi Cadwaladr University Health Board - Health
Case reference 201507133 - Report issued in April 2016
Mr A complained about Betsi Cadwaladr University Health Board's ("the Health Board") handling of his complaint against a contracted family health service provider in its area.

On receipt of the complaint, the Ombudsman contacted the Health Board and it accepted that there had been failures in respect of its complaint handling. The Ombudsman found that the Health Board had already taken steps to address the failings indentified and little further could be achieved through an investigation of Mr A's complaint.

The Health Board agreed to offer Mr A a formal apology for the poor handling of his complaint and to pay him £150 in recognition of any distress and inconvenience arising

Betsi Cadwaladr University Health Board – Health
Case reference 201505088 - Report issued in April 2016
Mr X complained to the Ombudsman that since the passing of his wife in 2009, he had been unable to "move on" emotionally as he felt that there were unanswered questions surrounding her passing.

On receipt of the complaint, the Ombudsman contacted Betsi Cadwaladr University Health Board ("the Health Board") to seek further clarification on its offer to arrange a meeting to try and resolve any issues. The Health Board agreed to arrange a meeting for the first week of March 2016.

Betsi Cadwaladr University Health Board - Health
Case reference 201600901 - Report issued in June 2016
Ms X complained about the treatment provided to her mother leading up to her diagnosis of colorectal cancer and in particular that a complaint was raised with Betsi Cadwaladr University Health Board ("the Health Board") on 7 July 2015 but, at the time of bringing her complaint to the Ombudsman, she had not received a response.

On receipt of this complaint, the Ombudsman contacted the Health Board to discuss the concerns and the delay in providing a response. He was advised that whilst a response had been drafted, it required checking and signing before it can be finalised. It was expressed to Ms X that, unfortunately, this process can take some time if further information is required and that in this case, the Ombudsman was assured that further clarification was required and, therefore, the complaint was not overlooked.

Ms X was advised that the Ombudsman considered it appropriate to allow the Health Board to retrieve that information in order that it can provide a full explanation.

Prior to providing the final response, the Health Board agreed to:

a) write to Ms X apologising for the delay and explaining why there had been a delay, and

b) provide a monetary sum of £200 in recognition of it.

Education

UPHELD

Ceredigion County Council - Other
Case reference 201502409 – Report issued in April 2016

Ms A complained that Ceredigion County Council ("the Council") failed to facilitate the reintegration of her son (B) into the school environment, the Council's School Transport Policy was not compliant with Welsh Government guidance and communication issues had been identified by the Council but it had not provided a remedy.

The Ombudsman found that the Council had adopted an intractable approach regarding the completion of two forms, one which Ms A had already completed and a second which she could not complete without information being provided by the Council. This resulted in the breakdown of a planned trial placement in a school for B. He also found that communication difficulties encountered by Ms A should be addressed. The Ombudsman did not uphold Ms A's complaint about the School Transport Policy as this did not have any impact on the complainant.

The Ombudsman recommended that the Council:

a) apologise to B

b) make a redress payment to B of £500 in recognition that the failings identified resulted in a lost opportunity to have a trial placement at a mainstream school

c) apologise to Ms A

d) provide financial redress of £100 in recognition of the communication failings already identified

e) provide complaint handling training for some members of staff, and

f) review its School Admissions Procedure.

The Council agreed to implement the recommendations.

EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

Student Finance Wales - Other
Case reference 201600944 - Report issued in June 2016

Mrs X complained that Student Finance Wales did not clearly communicate the specifications required for the equipment purchased by her daughter, Ms X, and felt that Ms X should be reimbursed for her purchase using her Disabled Student Allowance.

The Ombudsman found that Ms X was given incorrect information by a Student Finance Wales contact member prior to making her purchase. Student Finance Wales agreed to fully reimburse Ms X for her purchase, which was £279.99. Student Finance Wales noted that any further costs incurred in relation to the performance of the equipment would be incurred by Ms X as the equipment was not to the required specification.

Environment and environmental health

EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

Pembrokeshire County Council – Pollution and pollution control measures
Case reference 201505545 – Report issued in April 2016

Mr X complained that Pembrokeshire County Council ("the Council") failed to undertake an investigation of his complaint, referred to it in December 2013, on behalf of his sister Miss Y. The Ombudsman commenced an investigation into the Council's complaints handling of this matter.

Following contact from the Ombudsman and the Council's review of the papers on this complaint, the Council promptly acknowledged that it had not dealt with Mr X's complaint in accordance with its complaints policy. Additionally, the Council commenced and completed its formal investigation into Miss Y's original complaint providing a response within seven weeks thereafter, training for the relevant Complaints Officer, an interdepartmental email to all of the Contact Officers to ensure a clear understanding of their role and responsibilities under the Complaints Policy, and to review and ensure the Council has an up to date procedure manual for its Contact Officers.

Blaenau Gwent County Borough Council - Refuse collection. recycling and waste disposal
Case reference 201505684 - Report issued in April 2016

Ms X's complained to the Ombudsman about the troliblocs system that had been put in place by Blaenau Gwent County Borough Council ("the Council"). Ms X complained that the troliblocs were very heavy and difficult to manoeuvre. Ms X also stated that during bad weather, the troliblocs had a tendency to blow over.

On receipt of the complaint, the Ombudsman contacted the Council which agreed to arrange for a Warden to visit Ms X with the aim of resolving the outstanding issues.

Blaenau Gwent County Borough Council - Refuse collection. recycling and waste disposal
Case reference 201505971 - Report issued in April 2016

Mrs X complained that Blaenau Gwent County Borough Council ("the Council") failed to collect her refuse on a regular basis, and estimated that she was receiving a collection once every six weeks.

On receipt of the complaint, the Ombudsman contacted the Council. The Council agreed to:

a) ask the Wardens to visit Mrs X's property on the next refuse collection day to ensure a successful collection was made, and

b) contact Mrs X via telephone to discuss her concerns.

Wrexham County Borough Council - Refuse collection. recycling and waste disposal
Case reference 201600888 - Report issued in June 2016

Mrs A complained that despite raising a concern with Wrexham County Borough Council ("the Council") about missed refuse collection, further instances occurred.

The Council agreed that further collections had been missed and therefore the Ombudsman recommended that the Council:

(a) provide Mrs A with a full written apology for the service failure and an explanation of what went wrong

(b) offer Mrs A £50 in recognition of the service failure.

Vale of Glamorgan Council - Other
Case Reference 201600929 & 201601060 – Report issued in June 2016

The Ombudsman received a complaint about the way Vale of Glamorgan Council ("the Council) had addressed concerns about a dangerous retaining structure and who would be responsible for its repair and upkeep. The complaint (amongst other things) raised specific concerns about the length of time taken and communication with the owners of the properties affected by the potential hazard.

Following consideration by the Ombudsman, the Council agreed to write to the complainants setting out its response to concerns raised about the time taken in addressing the matter and communication issues.

Other elements of the complaint were outside of the Ombudsman's jurisdiction.

Finance and taxation

EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

Bridgend County Borough Council – Finance and Taxation
Case reference 201600772 - Report issued in June 2016

Mrs X complained that Bridgend County Borough Council ("the Council") failed to appropriately band her new build property for council tax purposes for two years, resulting in arrears.

The Ombudsman found that the Council had failed to advise Mrs X of the temporary nature of the council tax band that had been applied and further failed to take the necessary steps to ensure that it was revised.

The Ombudsman considered that the Council had already taken reasonable steps to alleviate the financial pressures that the arrears may have caused. However, he contacted the Council and it agreed to:

a) apologise and

b) pay a sum of £100 to Mrs X in recognition of any inconvenience caused and her time and trouble in pursuing the complaint.

Housing

EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

Grwp Gwalia Cyf Ltd - Repairs and maintenance
Case reference 201507026 – Report issued in April 2015

Mrs X complained to the Ombudsman about water ingress and dampness problems at her home address resulting in unsatisfactory living conditions and long delays in resolving matters which led to stress and anxiety.

On receipt of the complaint, the Ombudsman contacted Grwp Gwalia Cyf Ltd ("the Housing Association") for further information and an update. After considering the information provided, the Ombudsman did not consider a detailed investigation was needed as the Housing Association had identified high levels of condensation at the property and taken steps to remedy the issues. Further work had also been proposed to assist with the management of the condensation, and it had offered financial assistance for redecoration.

The Housing Association agreed to undertake the following in settlement of the complaint:

a) arrange an appointment with Mrs X at her home address within the next 15 working days (of the date of this summary) to discuss outstanding work at the property to include the issues of cavity wall, chimney stack and the guttering

b) provide Mrs X with an action plan detailing what work would be carried out and dates for completion of the proposed works. The action plan to be completed within 15 working days of the meeting at her home address.

Cardiff Council - Repairs and maintenance
Case reference 201507174 – Report issued in April 2016

Mrs A complained that Cardiff Council ("the Council") failed to carry out repair works to a leaking roof which has resulted in a change of living conditions.

On receiving the complaint the Ombudsman contacted the Council and it confirmed that there had been some breakdown in communication. It was agreed that the Council would:

a) provide Mrs A with a written apology for the delays caused and a summary of the actions agreed

b) offer Mrs A a payment of £150 for the delay in carrying out the repair work and time and trouble in raising a complaint.

It was also noted that the Council made a recent visit to the property and would attempt to carry out the repair work within 28 days of the visit.

Wales and West Housing Association - Repairs and maintenance
Case reference 201506860 - Report issued in April 2016

Mr T complained to the Ombudsman because he said that Wales and West Housing Association ("the Housing Association") had not responded to his request for an adapted bathroom to be reinstated to a family bathroom. Mr T said he then complained and received no response from WWHA.

The Ombudsman contacted the Housing Association for further information which agreed to the following:

a) to arrange a meeting with Mr T to discuss concerns

b) to reinstate a family bathroom as agreed to the meeting, and

c) to complete the work within two weeks.

Bron Afon Community Housing Ltd - Repairs and maintenance
Case reference 201505257 - Report issued in April 2016

Mrs A complained that Bron Afon Community Housing Ltd ("the Housing Association") had failed to adequately respond to damp problems in a flat owned by her and her brother under a leasehold agreement. She also complained that it had failed to deal with her complaint in a timely manner.

The Ombudsman found that the damp problem did not fall within the definition of an emergency repair and that part of the damp problem was within the flat, which was the owner's responsibility. This part of the complaint was not upheld.

However, the Housing Association had not resolved the complaint at stage 2 of its procedure. The Ombudsman recommended that the Housing Association:

a) contact Mrs A and arrange a local resolution meeting with her

b) write a letter of apology for the delay in dealing with her complaint, and

c) offer £150 ex gratia payment for time and trouble taken.

Tai Calon - Repairs and maintenance
Case reference 201506471 - Report issued in April 2016

Mr T complained to the Ombudsman following the fitting of a waste pipe in his property which resulted in water leaks that damaged his property. Mr T highlighted concerns with the level of customer service and the standard of complaint handling when raising his concerns directly with Tai Calon ("the Housing Association").

The Ombudsman found that the cause of the damage was a civil matter of liability and not one which the Ombudsman could make a judgement on. However, with regard to the handling of the complaint, the Ombudsman found that although the Housing Association's actions were reasonable overall, their actions did not adequately meet the Ombudsman's expectations of a body to maintain a customer-focused approach to complaint resolution, particularly in terms of managing customer's expectations,

and dealing with complaints in a flexible, sensitive and helpful manner. The Housing Association agreed to:

a) provide a further, more fulsome apology to Mr T, and

b) offer a small financial token of £50 to reinforce the sincerity of that apology.

Merthyr Valleys Homes - Repairs and maintenance
Case reference 201507097 - Report issued in May 2016

Mrs X complained on behalf of her father (Mr Y) of a failure to carry out repair work to his property which had been caused by a building company contracted by Merthyr Valley Homes ("the Housing Association") carrying out work to his neighbour's property. As a result, Mr Y suffered distress as he had to take time off work to speak to the Housing Association as they did not respond to his emails.

Having considered the complaint and the information provided, the Ombudsman formed the view that a detailed investigation was not required as repairs had already been carried and there was no evidence of any leaks or damage to Mr Y's property. Assurance was given by the Housing Association that if any defects become apparent in time they will be rectified.

The Housing Association agreed to undertake the following in settlement of the complaint within 20 working days of the issue date of the Ombudsman's report:

a) write a letter of apology to Mr Y for the delays in dealing with the complaint which fell outside of their complaints guidance

b) offer an ex gratia payment of £50 to reflect the time and trouble taken by the complainant in making the complaint and for the distress caused to Mr Y.

Merthyr Valleys Homes - Repairs and maintenance
Case reference 201600494 - Report issued in May 2016

Mrs X complained on 26 February 2016 that Merthyr Valley Homes ("the Housing Association") had not dealt with a matter of water penetration and damp at her home promptly or to a satisfactory standard. A deadline was agreed for completion of the works by 15 April and the Ombudsman's file was closed.

On 25 April Mrs X again contacted the Ombudsman as the work to her property had not been completed. On receipt of this complaint, the Ombudsman contacted the Housing Association for further information and an update. After considering the information provided, the Ombudsman did not consider a full investigation was required as the Housing Association had in the meantime taken steps to remedy the issues and a plan was in place to complete the outstanding works which the complainant was satisfied with. The Housing Association had also reimbursed the complainant the cost of replacing water damaged kitchen blinds.

The Housing Association agreed to undertake the following action within 20 working days of the date of this summary in settlement of the complaint:

a) write a letter of apology to the complainant for the delays in dealing with the complaint

b) offer an ex gratia payment of £50 to reflect the time and trouble taken by the complainant in making the complaint and the stress caused to her and her family.

Powys County Council – Repairs and maintenance
Case Reference 201600373 – Report issued in May 2016

Mr C complained that Powys County Council ("the Council") had failed to respond and deal adequately with damp and water ingress problems at his home. He also complained that the Council's communications with him were poor.

The Ombudsman recommended that the Council:

(a) contact him within 5 working days of my request.

(b) arrange a site meeting with him within 15 working days of contacting him.

(c) provide an action plan of agreed works within 10 working days of the site meeting.

The Council had already carried out recommendations(a) and (b)and agreed with all recommendations.

Ceredigion County Council – Repairs and Maintenance
Case reference 201506924 - Report issued in May 2016

Miss A complained that Ceredigion County Council's ("the Council") contractor caused damage to her property when it carried out improvement works, funded by a Disabled Facilities Grant. The Council had agreed to undertake further work to repair the damage; however, it was waiting for confirmation from Miss A before proceeding.

The Council agreed to arrange a meeting with Miss A and her surveyor within 20 working days, to discuss the outstanding required work and agree a way forward. The Ombudsman considered that the action which the Council said it would take was reasonable and would resolve Miss A's complaint.

Carmarthenshire County Council - Repairs and maintenance
Case reference 201506999 - Report issued in June 2016

Mrs X, who is elderly and disabled, complained about several repair issues regarding the condition of her property when her tenancy began in May 2015. Her primary complaint was regarding the failure of the central heating system and the distress and inconvenience that this caused her.

The repair aspects of her complaint were not considered suitable for investigation. However the central heating element of her complaint was considered suitable for settlement with Carmarthenshire County Council ("the Council").

The Council agreed to the Ombudsman's recommendation to make a redress payment to Mrs X for £650.

Carmarthenshire County Council - Repairs and maintenance
Case reference 201601096 - Report issued in June 2016

Mr D complained that Carmarthenshire County Council ("the Council") had failed to respond effectively in order to repair a defective central heating system in his home. This caused him to be without any heat in his home between October 2015 and February 2016.

The Council had apologised in a letter to the complainant, but, it was felt that it had not sufficiently addressed the hardship experienced by him during the period concerned. The Ombudsman made the following recommendations which the Council agreed to undertake:

a) write a further letter confirming its apology previously included in its response letter to Mr D, dated 18 April 2016

b) offer an ex gratia payment of £280 in recognition of the hardship suffered by Mr D during the winter of 2015.

RCT Homes - Repairs and maintenance
Case reference 201600987 - Report issued in June 2016

Ms B complained to the Ombudsman about the condition of her kitchen which was old and in a state of disrepair. Ms B said that an engineer had to repair a unit door which had fallen off. Ms B complained that when she asked for a replacement kitchen, she was informed by RCT Homes ("the Housing Association") that the kitchen upgrade was scheduled for the financial year 2016/17.

Following a discussion, the Housing Association agreed to:

a) Arrange for a surveyor to carry out a site visit to inspect the condition of the kitchen

b) look into expediting the kitchen upgrade should this be the recommendation of the surveyor.

Planning and Building Control

UPHELD

Flintshire County Council – Handling of planning application (other)
Case reference 201408787 - Report issued in May 2016
Mr and Mrs X complained about how Flintshire County Council ("the Council") approved a planning application for a development which included the construction of a dwelling whose flank wall was significantly closer to the front of their property than the minimum distance advised by the Council's own supplementary planning guidance dealing with space around dwellings.

The investigation found maladministration when a planning officer misinformed the local member that the application was in accordance with the guidance, when it clearly wasn't. The local member was considering whether the application should be called in to be determined by the planning committee.

The application was instead determined by the same planning officer under delegated powers.

The investigation found that the complainants had been caused an injustice in that there was significant uncertainty as to whether the application would have been approved if the maladministration had not occurred and the application had been determined by the planning committee.

The complaint was therefore upheld. The Ombudsman recommended that the Council:

a) apologise for the failings found

b) make a payment of £3,000 to reflect the uncertainty referred to above and the time and trouble expended by the complainants pursuing their complaint, and

c) review the wording of the relevant guidance to ensure that they were not overly prescriptive and that they were consistent with their advisory status.

The Council agreed to implement the recommendations.

Monmouthshire County Council - Other planning matters
Case Reference 201501740 – Report issued in May 2016
Mr C was dissatisfied with the failure by the Monmouthshire County Council's ("the Council") Local Planning Authority ("LPA") to properly carry out enforcement action against his neighbour Mr X. Since 2013, Mr X had repeatedly breached a planning condition to relocate a horse manure waste pile in sight of Mr C's property. A previous Council investigation, completed in September 2014, had identified failings including delays in the LPA using its enforcement powers and had made recommendations to prevent this happening again.

The Ombudsman's investigation found evidence of unreasonable delay in the LPA using its enforcement powers pre September 2014. However, poor record keeping, coupled with administrative failings/ mishaps, meant the Ombudsman could not preclude the possibility that after this date there continued

to be instances when Mr C's case had been allowed to drift for longer than it should. The Ombudsman therefore upheld Mr C's complaint.

The Ombudsman's recommendations included the Council apologising to Mr C, making a payment of £750 and learning lessons.

Pembrokeshire County Council - Handling of planning application (other)
Case reference 201600690 – Report issued in June 2016

Mr W complained that Pembrokeshire County Council ("the Council") took two years to determine the outcome of his planning application, and that when he complained the Council "blamed" him because he had not contacted them to establish the progress of his case.

The Ombudsman found that the delays in determining the application were excessive, and that the tone of the initial complaint response could be interpreted as placing the onus on Mr W to ensure his application progressed in a timely manner.

Upon being informed of these concerns, the Council immediately issued a sincere apology to Mr W and demonstrated how the systems and processes of the department were already improved. However, to compensate him for his personal injustice, the Ombudsman recommended that the Councilloffer Mr W £250 in redress.

Ceredigion County Council –Unauthorised development
Case Reference 201501463 – Report issued in June 2016

Mr A complained about Ceredigion County Council's ("the Council") handling of his concerns about a wind turbine erected next to his home. He complained about the decision to approve the application and about delays in addressing his complaints of noise nuisance and a breach of development control.

The Ombudsman partly upheld the complaint, having found some procedural and administrative errors in the Council's handling of the application and in its response to Mr A's concerns. The Ombudsman recommended that, in recognition of the identified failings, the Council should apologise and make a payment of £500 to Mr A, as well as reviewing and auditing its planning procedures.

NOT UPHELD

Denbighshire County Council - Handling of planning application (failure to notify those affected)
Case reference 201408558 – report issued in April 2016

Mr D complained that Denbighshire County Council ("the Council") did not properly consult him on an application to build a housing development on land adjacent to his home. He was also concerned that the effect on his amenity was not taken into account.

At the time the planning application was being considered, Mr D's house was under construction and unoccupied, although the roof and chimney can be seen from photographs taken during the site visit.

In relation to the consultation, the Council had met the statutory requirements for the type of application

by posting a site notice and publishing a notice in the local paper. As Mr D's house was still being built and was unoccupied, there was no address to send a notification letter to, and a search of the Council's files to find out Mr D's contact details would have been disproportionate.

In relation to the effect on Mr D's amenity, the Ombudsman found there was maladministration by the Council as it was not considered in the planning officer's appraisal of the application. However, this would not have affected the decision as the development was in accordance with the Council's planning policies and consequently there was no injustice to Mr D. Therefore the Ombudsman did not uphold the complaints.

EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

Ceredigion County Council – Other planning matters
Case reference 201505565 - Report issued in May 2016

Mr X complained about his dealings with Ceredigion County Council's ("the Council") planning department. In particular, he said that the department had given him contradictory advice about whether planning permission would be required for the construction of a wall outside his property, which was a listed building.

The Ombudsman found that the advice did not appear to be wrong; rather it was unclear because whether planning permission would be required depended on the exact plans, size and location of the wall. The Council agreed to hold a site meeting at the property with relevant staff to discuss the issue with Mr X in more detail. The Ombudsman's view was that this was an acceptable way forward and further investigation was not merited.

Social services - Adult

UPHELD

Conwy County Borough Council, Gwynedd Council and CSSIW
Case Numbers: 201500280/201500281/201500282
Mrs A and Mrs B complained about the investigation of the circumstances surrounding the death of their mother, Mrs C, after a stay in a care home. They said that:

a) Conwy County Borough Council (in whose area the home was situated) did not fully investigate Mrs C's death

b) Gwynedd Council (who had arranged Mrs C's placement in the home) failed to ensure a care plan was in place for her and did not get involved in the investigation

c) CSSIW did not fully investigate their complaint.

The Ombudsman found failings on the part of all three bodies:

a) failings in Conwy's handling of the POVA process, in its communication with Mrs C's family and in the way in which their complaint was handled

b) failings in Gwynedd's assessment of Mrs C's needs, in its review of her placement in the care home and in its engagement with the POVA process conducted by Conwy, and

c) failings in CSSIW's engagement in the POVA process and in its inspection of the care home.

The Ombudsman recommended that all three bodies:

a) apologise to Mrs A and Mrs B, and

b) put in place training and process reviews to prevent a re-occurrence of the failings identified.

He also recommended that Conwy make a payment of £250 to Mrs A and Mrs B in recognition of their time and trouble in pursuing their complaint.

Cardiff Council - Services for vulnerable adults
Case Reference 201500631 Report issued in May 2016
Mrs A complained about Cardiff Council's ("the Council") Adult Social Services Department and its failure to provide her with sufficient support after she became involved in her mother's care. Her concerns included the Council's failure to assess her mother's needs and safety as a vulnerable adult.

Mrs A also complained about the Council's poor communication and handling of her complaint.

The Ombudsman's investigation found that, although the Council failed to review Mrs A's mother's needs, there were safeguards in place to alert the Council should those needs change and a reassessment become necessary. He was also satisfied that the Council had considered Mrs A's concerns about her mother's safety as a vulnerable adult and that the protection of vulnerable adult process had been followed correctly. The Ombudsman did not uphold this aspect of Mrs A's complaint.

The investigation found, in terms of Mrs A's needs as a carer, that whilst the Council did offer support, these options proved impractical as Mrs A lived in another city. The Ombudsman was of the view that, had the Council, carried out a carer's assessment with Mrs A, as it was supposed to do, it would have helped identify support more tailored to meet her needs. He therefore found that the Council's inaction amounted to maladministration and upheld this aspect of Mrs A's complaint. The Ombudsman recommended that the Council apologise for this shortcoming and pay Mrs A the sum of £200.

EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

Flintshire County Council - Services for vulnerable adults (eg with learning difficulties. or with mental health issues)

Case reference 201506287 - Report issued in April 2016

Mr W complained about a decision taken by Flintshire County Council ("the Council") as part of a review of its Learning Disability Services. In particular Mr W was concerned that the Council had identified the supported living accommodation where his son lived as part of its Move On programme. Mr W said that the Council failed to appropriately captured his son's care needs as part of its decision making process.

The Council agreed to:

a) complete an independent reassessment of Mr W's son's needs, and

b) reapply the outcomes of the new assessment to the criteria summary sheet used as part of its identification and selection process.

Newport City Council - Services for People with a disability inc DFGs

Case reference 201506518 - Report issued in April 2016

Mr A complained to Newport City Council ("the Council") on 14 December 2015 about works carried out to his property under a Disabled Facilities Grant. Specifically, Mr A complained about the new route of hot and cold supply installation for the bathroom adaptation. Mr A said he was unaware that the pipe work would be exposed, which in his view ruined the bathroom. Mr A complained to the Ombudsman that the Council failed to provide a response to his complaint.

Following consideration of the complaint, the Ombudsman contacted the Council to discuss Mr A's concerns. The Council explained that Mr A's complaint was sent to it as a recorded delivery but it was issued to the incorrect department for dealing with the complaint. Following a telephone conversation between Mr A and the Council on 9 March 2016, the Council became aware of the circumstances of Mr A's complaint, and it agreed to provide him with a full written response.
The Ombudsman noted that the Council responded to the complaint on 6 April 2016.

Conwy County Borough Council – Services for vulnerable people
Case reference 201507045 Report issued in May 2016

Mrs A complained to the Ombudsman on behalf of her son, Mr B, about Conwy County Borough Council ("the Council") and its administration of his residential care placement.

Mrs A alleged that her son had been assaulted by another resident at the private care home on five occasions and said that the Council had not done enough to protect him from harm. Although Mrs A had asked the care home to investigate her concerns, the matter was not considered as a formal complaint and it had not been brought to the Council's attention.

On receipt of the complaint, the Ombudsman contacted the Council and it agreed to appoint an independent investigator to consider the matter in accordance with stage 2 of the statutory social services complaints procedure.

Newport City Council – Services for older people
Case reference 201600779 - Report issued in June 2016

Mr G complained that he had not received a response to a complaint he made to the Finance and Social Services Department of Newport City Council ("the Council") in 2015. Mr G raised concerns regarding the handling of his complaint because he had been advised that he would receive a response but the Council kept missing their target dates to do so.

The Ombudsman found that the Council had repeatedly promised action and then failed to provide a response to the complaint. Mr G had to wait seven months to receive a response. The Ombudsman considered this to be excessive, and recommended that the Council:

a) apologise to Mr G for the delay

b) offer £100 as a token of apology

c) expedite the response.

Caerphilly County Borough Council - Other
Case reference 201600821 - Report issued in June 2016

Mr X and Ms X made a complaint to Caerphilly County Borough Council ("the Council") on 7 February 2016. They received an acknowledgement on 12 February but no further response following this. The Ombudsman recommended the following settlement, which the Council agreed to undertake:

a) to send Mr X and Ms X a response to their complaint by 20 June 2016

b) to make a redress payment of £50 to them to reflect the time and trouble taken pursuing this complaint with the Council and this office.

Vale of Glamorgan Council - Services for People with a disability inc DFGs
Case Reference 201501219 – Report issued in June 2016

Ms A complained that the Vale of Glamorgan Council ("the Council") had not addressed her concerns,

about the domestic and personal care provided for her by three domiciliary care agencies ("the Agencies"), fully and robustly. She said that the Council's response to these concerns had been 'dismissive'. She also maintained that the Council had not discussed introducing double-handed visits, with her, beforehand and suggested that this was unreasonable.

The Ombudsman considered that the Council had not dealt with all of Ms A's concerns, about the care given to her by the Agencies, properly. He also decided that its communication with Ms A, about the double-handed visits, had been lacking. He concluded that it would be appropriate to try settling Ms A's complaint. The Council subsequently agreed to:

(a) write to Ms A to apologise for the service failings identified and to address her Agency-related concerns.

(b) share its letter, with the Ombudsman, before sending it to Ms A, in an effort to ensure that it satisfies the brief given.

(c) - discuss Ms A's complaint and its resolution with the Care and Social Services Inspectorate Wales

(d) pay Ms A a nominal sum of £250 for the service failings identified

(e) pay Ms A a nominal sum of £50 in recognition of the inconvenience, associated with pursuing her formal complaint, that she had experienced

(f) specify and highlight, within its 'Provider Performance Monitoring Protocol' ("the Protocol"), that concerns about quality standards include missed calls, unpunctual calls and those pertaining to a significant number of different carers caring for one service user

(g) share its revised Protocol with Ms A.

The Ombudsman considered that the action, which the Council had agreed to take, was reasonable. Accordingly, he regarded Ms A's complaint as settled.

Social services - children

UPHELD

Torfaen County Borough Council - Other
Case reference 201600101 - Report issued in April 2016

Mr W complained that that the support he received from Torfaen County Borough Council's ("the Council") Families First Service was below standard, which resulted in his son missing out on vital support within his school. Mr W also said that he was not kept informed and found the situation distressing because of the impact on his son.

The investigation found that Mr W had not yet complained to the Council, but that this was a failure of the complaint handling process which failed to advise Mr W correctly on how to escalate his complaint.

The Council agreed to undertake the following actions in settlement of the complaint:

(a) apologise to Mr W

(b) complete a full investigation of the original complaint and provide a Stage 2 response, and

(c) offer a sum of £25 redress for the time and trouble to Mr W.

EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

Torfaen County Borough Council - Children in care/taken into care/'at risk' register/child abuse/custody of children
Case reference 201600259 - Report issued in June 2016

Mrs A was unhappy with Torfaen County Borough Council's ("the Council") final response to her complaint about a child protection investigation involving her grandson. In particular, she was dissatisfied with the Council's written response to the Independent Investigator's report where it said, "I hope that the information contained within [the] report reassures you that the Local Authority did consider points 3.5.3 of the 2008 All Wales Child Protection Procedures." Mrs A felt that this statement was not supported by the Independent Investigator's findings.

On receipt of the complaint, the Ombudsman wrote to the Council and it agreed to write to Mrs A to acknowledge that, without the appropriate records having been made, it was not in a position to reassure her that everything was done in accordance with the All Wales Child Protection Procedures.

Various - other

EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

Vale of Glamorgan Council – Economic development
Case Number: 201506799 – Report issued in May 2016

Ms N, an owner occupier, complained about the way a renewal area group repair scheme ("the scheme") had been overseen by the Vale of Glamorgan Council ("the Council"). The scheme had been ongoing for many years, was problematic, and Ms N had complained about defective works undertaken by contractors. She also complained about how the Council had handled her complaints. An independent survey commissioned by the Council had identified a number of issues. The Council had subsequently agreed it would rectify the work at its cost. The Council also confirmed that it would issue a guarantee for the works to replace the void guarantees already provided by the contractors.

In light of limitations on his jurisdiction, and that many of the issues were now historical, the Ombudsman resolved to settle the complaint. The Council agreed to implement the following terms of settlement:

a) complete the outstanding works as soon as practicable

b) issue written confirmation of its guaranteeing the work on completion for a 10 year period (so such evidence could be placed with Ms N's title deeds)

c) offer a further written apology and redress of £300 for its complaint handling failures (payable within one month)

d) agree to reimburse Ms N for any out of pocket losses as evidenced by receipts (to be provided to the Council within three months)

e) pay Ms N the sum of £1,500 redress for her injustice arising from the protracted nature of the works and inconvenience (payable within one month).

Vale of Glamorgan Council – Economic development
Case Reference 201506800 - Report issued in May 2016

Mr D, an owner occupier, complained about the way a renewal area group repair scheme ("the scheme") had been overseen by the Vale of Glamorgan Council ("the Council"). The scheme had been ongoing for many years, was problematic, and Mr D had complained about defective works undertaken by contractors. He also complained about how the Council had handled his complaints. An independent survey commissioned by the Council had identified a number of issues. The Council had subsequently agreed it would rectify the work at its cost. The Council also confirmed that it would issue a guarantee for the works to replace the void guarantees already provided by the contractors.

In light of limitations on his jurisdiction, and that many of the issues were now historical, the Ombudsman resolved to settle the complaint. The Council agreed to implement the following terms of

settlement:

a) complete the outstanding works as soon as practicable

b) issue written confirmation of its guaranteeing the work on completion for a 10 year period (so such evidence could be placed with Mr D's title deeds)

c) offer a further written apology and redress of £300 for its complaint handling failures (payable within one month)

d) agree to reimburse Mr D for any out of pocket losses as evidenced by receipts (to be provided to the Council within three months)

e) the sum of £1,500 redress payable for his injustice and inconvenience – such sum was off-set against the means tested financial contribution payable by Mr D.

Betsi Cadwaladr University Health Board - Poor/No communication or failure to provide information
Case Reference 201600449 – Report issued in May 2016

Mr G complained that Betsi Cadwaladr University Health Board ("the Health Board") had failed to provide a response to his complaint within a reasonable time frame. He said that he had written on 15 December 2015 to lodge a complaint and in April 2016 had still not received a substantive response.

The investigation found that the Health Board had written in December, January and February to indicate that the investigation was ongoing but the Health Board took over 4 months to provide its response. The Ombudsman considered that the initial complaint matter was not overly complex, and therefore this delay was excessive.

The Ombudsman therefore recommended that the Health Board undertake to:

(a) provide a full apology and explanation for the delay

(b) expedite the full and final response within 3 weeks.

Isle of Anglesey County Council – Other miscellaneous
Case reference 201506705 - Report issued in June 2016

Mr G complained that the Isle of Anglesey County Council ("the Council") had delayed or failed to properly follow procurement due process in relation to his wife, Mrs G's, tender for the purchase of a Council business asset sale. It had initially indicated that Mrs G's tender had been successful. After some months, the Council withdrew from the sale. Throughout Mrs G was legally represented and Mr G complained that the Council had by its actions put his wife and the family to unnecessary expense, acted unfairly in withdrawing, and had not given him or Mrs G, when they requested through her solicitor, adequate reasons for its decision.

On examining the documents, the Ombudsman found that the Council had properly followed due process. When there were changes to Mrs G's original accepted tender, the Council was entitled (still at pre contract stage), under procurement law, to seek certain further information to satisfy itself. This was particularly relevant when Mrs G's revised position meant she was offering a reduced price. So whilst it was not for him to question the Council's decision, the Ombudsman felt there were plausible reasons for

it.

Nevertheless, the Council failed to acknowledge or respond to Mrs G's solicitor's written request for further clarity about its decision (albeit it had advanced some reasons). In responding to Mr G's complaint, the Council sought to rely on a document it said entitled it to abandon the process for any reason. However, when asked by the Ombudsman it was unable to produce it. The Ombudsman found that the Council had failed to respond to a legitimate written request. It had further misinformed Mr G when he complained. The Ombudsman made the following recommendations, all of which the Council agreed to implement within one month:

a) provide a written apology to Mr G (and through the letter to Mrs G) for failing to respond to her solicitor's letter and for the subsequent misinformation in its complaints response to Mr G

b) in recognition of these failings it should offer Mr & Mrs G redress of £400 for their time and trouble in pursuing the complaint.

Rhondda Cynon Taf County Borough Council – Other miscellaneous
Case reference 201601424 - Report issued in June 2016

Mr L complained that Trading Standards investigated his consumer dispute and obtained a prosecution against the trader, but failed to make an application for compensation on your behalf when the matter was taken to Court.

The Ombudsman found that the relevant documentation to Mr L's Compensation Order was misplaced by the department, resulting in a failure to submit his claim for compensation and ultimately Mr L was left with no other choice but to undertake Civil Court proceedings himself.

Rhondda Cynon Taf County Borough Council ("the Council) agreed to implement the following recommendations:

a) provide a fulsome apology to Mr L
b) offer £250 redress for inconvenience, time and trouble
c) offer Mr L a further £115 to cover his costs to apply independently to the Civil Court.

Cardiff Council – Other miscellaneous
Case reference 201600298 - Report issued in June 2016

Ms A complained that Cardiff Council ("the Council") failed to collect her recycling bags. Ms A previously raised a concern with the Council and it responded in January 2016 apologising and given assurances that the issues had been dealt with. Since that time Ms A had experienced further problems with the service.

The Council agreed to:

a) provide a full explanation of what action will now be taken to ensure that the issues do no reoccur

b) offer Ms A £100 for the time and trouble.

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 Matthew.Aplin@ombudsman-wales.org.uk or Lucy.Geen@ombudsman-wales.org.uk, or sent to the following address:

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Report of the Head of Democratic Services

Standards Committee – 7 October 2016

ATTENDANCE AT COMMUNITY / TOWN COUNCIL MEETINGS BY MEMBERS OF STANDARDS COMMITTEE - PROTOCOL

Purpose:	To provide guidance to Members of the Standards Committee should they attend and observe Community / Town Council meetings.
Policy Framework:	None.
Consultation:	Access to Services, Finance, Legal.
Recommendation(s):	It is recommended that:
1)	The Protocol be adopted.
Report Author:	Huw Evans
Finance Officer:	Carl Billingsley
Legal Officer:	Tracey Meredith
Access to Services Officer:	Phil Couch

1. Introduction

1.1 Standards Committee at its meeting on 3 June 2016 resolved that the Head of Democratic Services and Deputy Head of Legal & Democratic Services / Deputy Monitoring Officer draft a document outlining the remit and scope of Members of the Standards Committee attending Community / Town Council meetings as an evidence gathering exercise.

1.2 The intention being to observe, monitor and improve ethics and standards linked to the Code of Conduct within Swansea.

1.3 The Head of Democratic Services liaised with a number of Welsh Authorities in order to establish how they dealt with such attendance.

1.4 A draft protocol outlining the remit and scope of such visits is outlined below.

2. Community / Town Councils

2.1 There are 24 Community / Town Councils within the City and County of Swansea. They are:

Community Councils		
Bishopston	Llangyfelach	Penrice
Clydach	Llanrhidian Higher	Pontlliw & Tircoed
Gowerton	Llanrhidian Lower	Port Eynon
Grovesend	Mawr	Reynoldston
Ilston	Mumbles	Rhossili
Killay	Penllergaer	Three Crosses
Llangennith, Llanmadoc & Cheriton	Pennard	Upper Killay

Town Councils		
Gorseinon	Llwchwr	Pontarddulais

3. Attendance at Community / Town Council Meetings by Members of Standards Committee - Protocol

3.1 **Remit.** Members of the Standards Committee may visit Community / Town Councils in order to observe how the meeting was conducted and whether there were any Councillors' Code of Conduct issues.

3.2 Attendance by Members of the Standards Committee at such meetings will be in the same capacity as members of the public.

3.3 The Standards Committee Members may introduce themselves prior to a Community / Town Council meeting commencing; however they need to make it abundantly clear that their attendance is that of a member of the public.

3.4 It is proposed that Members of the Standards Committee agree in advance which Community / Town Council meetings they will be visiting. This is proposed so as to prevent all members turning up to observe the same Community / Town Council.

3.5 Members of Standards Committee are also advised not to attend the same Community / Town Council too often so as to ensure that they gain a wider experience of how Community / Town Councils operate.

3.6 **Scope.** To feedback to the Standards Committee, members' observations of Community / Town Council meetings. Members of Standards Committee should take care not to participate in any meetings which they observe. As members of the Standards Committee their attendance is only to observe meetings and therefore **no** Co-opted Member Payment or mileage allowance will be paid.

3.7 **Feedback to Standards Committee.** Feedback from visits to Community / Town Council Meetings will be by way of a verbal update and will become a standing agenda item for the Committee however it is unlikely that there will be feedback at each meeting.

3.8 Members need to ensure that they do not put themselves inadvertently in a position of conflict in the event that there is a live complaint to the Public Service Ombudsman for Wales outstanding or where a complaint may subsequently be made in relation to any Community / Town Council visited.

3.9 Any queries in relation to any visit should be addressed to the Monitoring Officer.

3.10 Members of the Standards Committee are reminded that they themselves are also subject the Councillors' Code of Conduct.

4. Equality and Engagement Implications

4.1 There are no direct equality or engagement implications associated with this report.

5. Financial Implications

5.1 There are no different financial implications associated with this report.

6. Legal Implications

6.1 There are no legal implications associated with this report.

Background Papers: None.

Appendices: None.