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Bridgend County Borough Council

Cyngor Bwrdeistref Sirol Pen-y-bont ar Ogwr

Civic Offices, Angel Street, Bridgend, CF31 4WB / Swyddfeydd Dinesig, Stryd yr Angel, Pen-y-bont, CF31 4WB

Legal and Regulatory Services /
Gwasanaethau Cyfreithiol a Rheoleiddiol
Direct line / Deialu uniongyrchol: 01656 643385
Ask for / Gofynnwch am: Sarah Daniel

Date / Dyddiad: Wednesday, 20 January 2016

Dear Councillor,

STANDARDS COMMITTEE

A meeting of the Standards Committee will be held in the Committee Rooms 2/3, Civic Offices Angel Street Bridgend CF31 4WB on **Tuesday, 26 January 2016** at **2.00 pm**.

AGENDA

The Minutes and Report relating to the following items are not for publication as they contain exempt information as defined in Paragraph 12 of Part 4, and Paragraph 21 of Part 5 of Schedule 12A of the Local Government Act 1972, as amended by the Local Government (Access to Information) (Variation) (Wales) Order 2007.

If following the application of the public interest test the Committee resolves pursuant to the Act to consider these items in private, the public will be excluded from the meeting during such consideration.

Yours faithfully
P A Jolley
Assistant Chief Executive Legal and Regulatory Services

Distribution:

Independent Members	County Borough Councillors	Town/ Community Councillors
Mrs B Heller	Cllr R D Jenkins	Mrs A Davies
Ms M Powell	Cllr D R W Lewis	Mr R J Hancock
Mrs J Kiely		
Mr C Jones		

MINUTES OF A MEETING OF THE STANDARDS COMMITTEE HELD IN COMMITTEE ROOMS 2/3, CIVIC OFFICES ANGEL STREET BRIDGEND CF31 4WB ON THURSDAY, 17 SEPTEMBER 2015 AT 2.00 PM

Present

Councillor M Powell – Chairperson

Independent Members:

Mr J Bevan
Mrs B Heller

Town/Community Council Member:

Councillor R J Hancock

County Borough Council Members:

Councillor D R W Lewis
Councillor R D Jenkins

Officers:

Andrew Jolley	Assistant Chief Executive Legal & Regulatory Services and Monitoring Officer
Laura Griffiths	Senior Lawyer
Andrew Rees	Senior Democratic Services Officer - Committees

104. APOLOGIES FOR ABSENCE

Apologies for absence were received from the following member of the Committee for the reason so stated:

Mr John Bevan – Hospital appointment.

105. DECLARATIONS OF INTEREST

None.

106. APPROVAL OF MINUTES

RESOLVED: That the minutes of the Standards Committee of 2 July 2015 be approved as a true and accurate record.

107. URGENT ITEMS

There were no urgent items.

108. EXCLUSION OF THE PUBLIC

RESOLVED: That under Section 100A(4) of the Local Government Act 1972 as amended by the Local Government (Access to Information) (Variation) (Wales) Order 2007, the public be excluded from the meeting during consideration of the following items of business, as the minutes/report contains exempt information as defined in Paragraph 12 of Part 4 of Schedule 12A and Paragraph 21 of Part 5 of Schedule 12A of the Act:-

Following the application of the public interest test it was resolved that pursuant to the provisions of the Act referred to above, to consider the under-mentioned items in private with the public being excluded from the meeting, as it would involve the disclosure to them of exempt information as stated above.

109. APPROVAL OF EXEMPT MINUTES

110. PROCESS FOR INTERVIEW OF SHORTLISTED CANDIDATES FOR INDEPENDENT REPRESENTATIVE ON THE STANDARDS COMMITTEE

The meeting closed at 3.30 pm

BRIDGEND COUNTY BOROUGH COUNCIL

REPORT TO STANDARDS COMMITTEE

26 JANUARY 2016

REPORT OF THE MONITORING OFFICER

WELSH GOVERNMENT CONSULTATION DOCUMENT – CONDUCT OF LOCAL GOVERNMENT MEMBERS

1. Purpose of Report

1.1 To advise the Committee of two draft statutory instruments to be made under Part III of the Local Government Act 2000 in relation to the conduct of Local Government Members in Wales and related matters:

- The Local Government (Standards Committees, Investigations, Dispensations and Referral) (Wales) Regulations 2016; and
- The Local Authorities (Model Code of Conduct) (Wales) (Amendment) Order 2016

2. Connection to Corporate Improvement Plan / Other Corporate Priority

2.1 Standards are an implicit requirement in the successful implementation of the Corporate Themes.

3. Background

3.1 The Welsh Government's 'Programme for Government' included a commitment to review the process for making an allegation that a local government member may have breached the member Code of Conduct, to ensure that it remains fit for purpose. The draft Statutory Instruments give effect to this and related matters.

3.2 Welsh Government issued a Consultation at the end of November 2015 on the drafting of the Statutory Instruments and in order to facilitate completion of the legislative process before the Elections in May 2016, the consultation period was limited to six weeks, closing on 10 January 2016.

4. Current Situation / Proposal

4.1 The background to the consultation is available at the following link http://gov.wales/consultations/localgovernment/amendments-to-subordinate-legislation/?lang=enset and outlines the following key proposals which are pertinent to the work of the Standards Committee:

<u>Obligation to report potential breaches</u>
It is proposed that this obligation is removed from the model Code in order to support non-statutory local protocols for resolving low-level member-on-member complaints. Whilst it will still be open for a member to refer such matters to the Ombudsman, the Ombudsman has indicated that he is likely to refer the matter back for local resolution in the first instance.

<u>Constituency Interests</u>
It is proposed to omit paragraph 10(2)(b) from the Model Code which provides that

a Member has a personal interest in a matter if a member of the public might reasonably perceive a conflict between their role in taking a decision on that matter on behalf of the Authority as a whole, and their role in representing the interests of constituents in their ward or electoral division, as appropriate. This aspect has given rise to unintended consequences in its practical application. The equivalent provision in the 2001 Model Code of Conduct was framed so as to apply to an executive member acting alone in taking a decision on behalf of the Authority. The wider wording of the provision in the 2008 Code has been read by authorities as applying to Members when acting collectively, e.g. on a planning or licensing committee, and has been seen as potentially precluding members from participating in any decisions affecting their ward.

<u>Term of Office</u>
The term of office of a member of a local authority or a community committee member serving on a standards committee is currently limited to the shorter of four years or the period to the next ordinary election following that member's appointment. It is proposed that this be extended until the date of the next ordinary election following the Member's appointment.

<u>Joint Standards Committees</u>
There are various provisions including maintaining the maximum limit of 9 Members, providing for no more than 1 Executive Member from each constituent authority and provisions relating to the servicing of such committees.

<u>Publication of misconduct Reports – Exemption</u>
There is a proposal that a Committee may exempt from publication agendas, records or information connected to the consideration of misconduct report until such time as the misconduct proceedings are concluding which may be until receipt of notification or, the conclusion of an appeal to the Adjudication Panel.

<u>Referral of misconduct cases</u>
There is provision for a Standards Committee to refer alleged breaches of the Code of Conduct to a different Standards Committee where the home Standards Committee considers it may have a conflict of interest.

<u>Period of suspension</u>
The Regulations are amended to make it clear that a period of suspension cannot exceed the remainder of a member's term of office.

<u>Appeals to the Adjudication Panel for Wales</u>
The proposal is to remove the right of appeal against the determination of a Standards Committee and imposing a requirement for a Member wishing to appeal to first obtain the permission of the President of the Panel. This is to ensure that only those appeals that have a reasonable prospect of success will proceed.

<u>Referral of Dispensation Applications</u>
There is provision for the Committee to refer an application for dispensation to another Authority's Committee for consideration.

<u>Criteria for Granting Dispensations – Disability</u>
As a general principle, the Welsh Ministers consider that a member with a prejudicial interest in any business being considered by that member's authority at a meeting should comply with the Code of Conduct and disclose that interest and withdraw from the meeting. The Welsh Government is aware that requiring a member with a disability to withdraw from a meeting could be problematic for that member. In such circumstances, an authority would be obliged to consider making reasonable adjustment (short of requiring the member to withdraw from the meeting) to accommodate that member's disability, for example, by

placing the item of business in which the member has an interest at the end of the agenda.

5. Effect upon Policy Framework& Procedure Rules

5.1 The proposals, if adopted, will result in amendments to the Model Code.

6. Equality Impact Assessment

6.1 The report is in relation to a consultation by Welsh Government proposing amendments to legislation and therefore it is for Welsh Government to carry out formal equality impact assessments in respect of their proposals.

6.2 It should be noted that one of the proposals, if adopted will have a positive impact for Members with disabilities.

7. Financial Implications

7.1 There are no immediate budgetary implications arising from this report.

8. Recommendation

8.1 It is recommended that the Committee note the report.

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Background documents
Welsh Government Consultation Document – Local Government Act 2000 Part III, Conduct of Local Government Members (30 November 2015)

BRIDGEND COUNTY BOROUGH COUNCIL

REPORT TO THE STANDARDS COMMITTEE

26 JANUARY 2016

REPORT OF THE MONITORING OFFICER

OMBUDSMANS CASEBOOK

1. Purpose of Report

1.1 To provide Members with a summary of cases that have been undertaken by the Ombudsman's Office from July 2015 to September 2015.

2. Connection to Corporate Improvement Plan / Other Corporate Priority

2.1 Standards are an implicit requirement in the successful implementation of the Corporate Themes.

3. Background

3.1 The Ombudsman's Casebook is published on a quarterly basis and contains the summaries of all reports issued during the quarter, as well as a selection of summaries relating to quick fixes and voluntary settlements.

4. Current situation / proposal

4.1 The Casebook for the period July 2015 to September 2015 is attached at **Appendix 1** and contains the summaries of those cases for which the hearings by the Standards Committee or Adjudication Panel for Wales have been concluded and the outcome of the hearing is known.

5. Effect upon Policy Framework& Procedure Rules

5.1 None.

6. Equality Impact Assessment

6.1 None.

7. Financial Implications

7.1 None.

8. Recommendations

8.1 The Committee is recommended to note the report.

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Background Documents
None

The Ombudsman's Casebook

Issue 22 October 2015

Inside this issue

A word from the Ombudsman

Go set a watchman for Wales!

October has been a busy month. I had the pleasure of returning to my old comprehensive school, Ysgol Gyfun Llangefni , where I was interviewed about a draft PSOW 2015 Bill which I anticipate imminently. I was also asked to give the keynote speech at the Standards and Ethics Conference.

The combination of these events forced me to reflect, but a trip down memory lane inspired my theme for the conference. Going back to school, 28 years on, reminded me of the debt I owed to those who had educated me and how my development had been profoundly affected by lessons that still impact on me now. It goes to show the importance of excellent public services!

In 1985 the English Language O level syllabus in Ysgol Gyfun Llangefni included "To Kill a Mockingbird" a book that I've always loved, and which I re-read this summer before the sequel "Go set a Watchman" which was finally published this summer.

As a young school boy full of idealism, I was outraged by the injustice and racism of 30s Alabama and the disgraceful treatment of Tom Robinson, a clearly innocent man victimised for his colour. Atticus Finch emerged as an archetypal hero. The noble, modest, fair-minded and dedicated small town lawyer determined to pursue justice, despite the risks it posed to his reputation, to his own personal safety and to that of his family in a tight knit community where everyone new everyone else. His conscience dictated that he simply has to defend Tom Robinson the best he can to do otherwise would be the end of honour.

(Continued overleaf)

30 years on and this year Harper Lee's sequel caused controversy; Atticus Finch is now for some a racist. But the controversy around the publication of the sequel (or was it a prequel?) loses sight of its broader message. Go set a Watchman attempts to give a broader message for the grown up. However much we admired the stiff upper lipped, resolute and slightly patriarchical hero our admiration for him, his daughter's admiration for him, cannot be used as some form of moral crutch for adulthood. Everyone needs to be true to their own consciences.

As Atticus's brother says:

"Every man's island...every man's watchman, is his conscience. There is no such thing as a collective conscious."

It is a call for an awakening, and a challenge to show personal leadership, and to reject "followship"!

If only life was that simple, a utopia of "properly set watchmen", then there'd be no need for the Nolan principles – and maybe no need for Ombudsmen (there may be those who believe that anyway!)

Do I believe that the Nolan principles are necessary for higher standards in Public life and public services? Yes. But are they sufficient? I think that as currently contrived, in a Welsh context the answer has to be "Not quite". To me the seven principles are not of equal importance- the seventh – Leadership is vital. It is leadership, genuine, dogged, determined and decent leadership which ensures and assures the other 6 principles - good leaders offer selflessness, integrity, objectivity and honesty and have no fears of accountability and openness. It is leadership that is the core to higher standards in public life and in a diverse country with distributed levels of authority and leadership; we all need to "set a watchman for Wales".

Nick Bennett
Ombudsman

Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

Lessons Learnt

Reducing the distress of dying - why improvements are needed to end of life care

End of life care is care that "helps all those with advanced, progressive, incurable illness to live as well as possible until they die".

This quarter, the Ombudsman had reason to publish a Public Interest Report (201405067) which related to the care of the complainant's late husband during his last few weeks suffering with terminal brain cancer. In our report, the complainant's late husband's discharge from hospital lacked effective communication, and there were no proper arrangements or services put in place for his care at home. In addition to this, he was not offered appropriate clinical treatment which could have controlled his symptoms, and prolonged his life expectancy even for a short time. Interestingly, this report is published during the same month that the media reported the UK coming top of the 2015 Quality of Death Index across 80 countries for its palliative care.

Another case (201403262) found that the health board had failed to provide sufficient palliative care to a woman with cancer, and it was recommended to the Health Board that it should conduct a review of its staff training to ensure that the failings found in the report were not repeated in the future. In a further case (201401141) the family complained that the fact their relative had been placed on the end of life care pathway was not communicated to them, which caused them a great deal of added distress. The theme of end of life care has been touched on in previous casebooks. In Casebook 16, two cases highlighted poor end of life care. Case 201203692 resulted in the Health Board being advised to introduce an end of life care pathway for dying patients, yet despite our recommendation the same health board features in our public interest report above. In case 201203947, the Ombudsman determined that 'there had been a failure to fully comply with National Guidance in respect of the end of life care discussions and arrangements' and the Health Board was advised to consider this as a matter for service improvement.

Despite Britain currently leading the way for palliative care, it continues to emerge from the complaints we receive as an area for improvement amongst health boards in Wales. With an ageing population, the quality of end of life care is becoming increasingly important, and so there is no room for health boards to become complacent.

It is clear from the cases highlighted above that a key aspect of providing good end of life care is clear, effective communication with both the patient and the family. In the public interest report, we found that 'the lack of communication (...) about the drugs in particular could have resulted in serious consequences' whereas in the second case, the family were not even told that their relative's care had been changed to end of life arrangements.

Communication is not a theme we are unfamilar with, and is something that emerges again and again in our investigations across all sectors. Health boards, along with all public bodies, must do more to improve how they communicate.

Key questions

Are we doing everything we can to ensure the end of life care we offer is as good as it can be?

If a patient has been placed on the end of life care pathway, has this been communicated to the family?

Can we do more to improve communications at all stages of the care we provide?

Case Summaries

Health

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

Betsi Cadwaladr University Health Board - Appointments/admissions/discharge and transfer procedures
Case reference 201405067 – Report issued in September 2015
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 the Ombudsman's 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 the Ombudsman's 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 the Ombudsman's clinical advisers. An action plan to deal with resulting actions to avoid recurrence should be prepared and shared with the Ombudsman.

Other reports - Upheld

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case reference 201400725 – Report issued in July 2015

Ms A complained about delays before Betsi Cadwaladr University Health Board ("the Health Board") provided her with an appointment for primary assessment and subsequent treatment of her symptoms. As a result of these delays, in excess of the 26 week referral to treatment waiting time target ("the RTT waiting time") set by the Welsh Government, Ms A said she was forced to fund private treatment to alleviate the debilitating effect of her symptoms. Ms A also raised concerns about the Health Board's handling of her complaint. She said that the Health Board did not acknowledge her letters or respond to them in a timely manner. Furthermore, it failed to address her main concern about the lack of treatment for her ongoing medical condition.

The investigation found that the Health Board failed to manage Ms A's waiting time in accordance with the relevant guidelines and that there were unacceptable call waiting times to get through to its booking centre to fit in with requirements of the booking process. As a result, the Health Board did not provide Ms A with accurate information, at the right time, to allow her to make informed choices about her own care pathway. She was not able to choose appointments that she was able to attend, causing unnecessary delays. The Health Board also failed to provide Ms A with an update when it was not able to respond to her first letter of complaint within 30 working days.

The Ombudsman recommended that the Health Board should:

a) provide an apology to Ms A and make a redress payment of £250 for the failings identified;
b) undertake a process review of its compliance with the current guidelines and, where necessary, amend its practice to ensure that it is managing its waiting lists in accordance with the guidelines;
c) review its current referral and booking correspondence with patients to ensure that it is providing meaningful information about waiting list times, the anticipated process and the patient's responsibilities to assist the NHS whilst waiting to be seen, in accordance with the guidelines;
d) undertake an audit of its booking centre telephony system waiting times against agreed performance measures;
e) consider other ways in which patients might be able to contact the booking centre and how it can be more responsive to peak demand;
f) remind staff dealing with complaints of the need to provide updates to complainants where

responses are not achieved within 30 working days.

Aneurin Bevan University Health Board - Clinical treatment outside hospital
Case reference 201405657 Report issued in July 2015
Mrs X complained that her Dentist carried out unsatisfactory dental work and did not follow normal dental procedures. Mrs X said that as a consequence she suffered pain/discomfort which was not responded to and she expressed concern about the cosmetic results. Mrs X also said that she has had to suffer the trauma of further investigation and treatment.

Mrs X also complained that the Dentist's response to her complaint was delayed and inaccurate. The Ombudsman found that the standard of dental care provided to Mrs X was unsatisfactory and he upheld Mrs X's complaint about the clinical care that she received. He also said that it was a serious shortcoming that there was no evidence that treatment plans had been agreed and updated as required. He noted that Mrs X had suffered a significant injustice as a result of this unacceptable clinical care.

Furthermore, the Ombudsman was concerned about the poor record keeping in this case. The Ombudsman also found that the Dentist's complaint response was limited. He said that due to the significant shortcomings in record keeping it was not possible for the Dentist to provide sufficient evidence to support his response. The Ombudsman said that it was also not clear that Mrs X had been advised of the next steps in the process and said the response was also slightly delayed. The Ombudsman partially upheld this element of the complaint.

The Ombudsman recommended that:

a) the Dentist complied with his NHS contract and provided treatment plans as required; and that
b) the Dentist undertook further training in the fitting of crowns and in record keeping.

Mrs X declined the recommendation of an apology and financial redress (£5,000 in respect of clinical care/distress and £250 for shortcomings in complaint handling) at the time of issuing the report. Mrs X was given an opportunity to review her position within one month.

Hywel Dda University Health Board - Clinical treatment in hospital
Case reference 201404798 - Report issued in July 2015
Mr A complained about the care and treatment that his late wife received from November 2012 until she sadly passed away. In particular, he complained that a Consultant Physician ("the first Consultant") had delayed his wife's diagnosis and treatment by 18 weeks. He also complained about an unnecessary appointment that was arranged by the first Consultant. Mr A said that his wife spent an unnecessary 32 days in hospital. Finally, he complained about the delay in Hywel Dda Health Board ("the Health Board") responding to his complaint.

The Ombudsman's investigation concluded that the care and treatment offered to Mr A's wife was appropriate, reasonable and timely. He did not uphold this aspect of Mr A's complaint.

In relation to the unnecessary appointment the Ombudsman accepted the Health Board's explanation that this was an administrative error. Inconvenience was caused to Mr A and his wife as a result and to that extent the Ombudsman upheld Mr A's complaint.

Finally, in relation to the Health Board's handling of Mr A's complaint the Ombudsman was of the view that the delay in responding to Mr A was unreasonable and upheld Mr A's complaint.

The Ombudsman recommended that the Health Board should apologise to Mr A in writing and offer a sum of £350 in recognition of the administrative failings which caused him distress and which extended to delays in responding to his complaint.

Cardiff and Vale University Health Board - Clinical treatment in hospital
Case reference 201404841 - Report issued in July 2015

Mrs A complained about the care and treatment her late mother received from Cardiff and Vale University Health Board ("the Health Board") in November 2013. Mrs A said that her mother's premature discharge on 28 November led to her mother being re-admitted to Llandough hospital ("the Hospital") on 6 January 2014 with pneumonia. She also complained about the Health Board's poor complaint handling which included delays in the complaint response.

Overall, the Ombudsman's investigation found no shortcomings in the care provided to Mrs A's mother. The Ombudsman was also satisfied that Mrs A's mother was clinically fit for discharge therefore he did not uphold this aspect of Mrs A's complaint.

However, the Ombudsman's investigation identified administrative failings in terms of record keeping and poor complaint handling and therefore upheld this aspect of Mrs A's complaint.

The Ombudsman recommended that the Health Board should:

a) apologise to Mrs A for the shortcomings identified in this report
b) remind staff of their responsibilities in terms of record keeping in compliance with the NMC guidance
c) provide evidence of the systems it has in place to monitor discharge planning and completion of appropriate documentation
d) make a payment of £250 in recognition of the delay in responding to Mrs A's complaint in a timely manner and the inconvenience this has caused her.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital
Case reference 201405111 Report issued in July 2015

Mrs A's complaint concerns the timeliness of her daughter's care and treatment and Abertawe Bro Morgannwg University Health Board's ("the Health Board") handling of her complaint. Mrs A said that the Health Board's complaint response was not open and transparent. She referred to a draft complaint response that the Health Board sent to her by mistake which referred to breaches in duty of care but that the final letter to her concluded that there has been no breach of duty in her daughter's care. Mrs A said that her daughter suffered distress as a result and that she should be compensated. Mrs A also expressed dissatisfaction with the way the Health Board had dealt with her complaint.

The Ombudsman's investigation considered that overall there were some shortcomings in the care provided to Mrs A's daughter which included failure to give her daughter analgesia, escalate her care to the surgical decision making unit and poor record keeping. The Ombudsman concluded that the failure to prescribe pain medication and to escalate her daughter's care caused her distress and upheld this aspect of Mrs A's complaint.

The Ombudsman's investigation highlighted that there was a delay in carrying out the surgery; however, he did not consider that the delay had caused any significant injustice to Mrs A's daughter and did not uphold this aspect of her complaint.

The Ombudsman considered that the Health Board's response was reasonable and accurate. He was pleased to note that the Health Board recognised that receiving the working copy of the response would have caused Mrs A distress and offered her monetary redress, and it is only to that extent that the Ombudsman upheld Mrs A's complaint.

The Ombudsman recommended that the Health Board should:

a) write to Mrs A's daughter to apologise for the failings identified by the Ombudsman's investigation
b) provide a redress payment to Mrs A's daughter of £400 for the distress caused by the failings
c) pay Mrs A £250 for the time and trouble in pursuing the complaint
d) reinforce with the treating clinicians the importance of good communication with patients regarding treatment options. It should also emphasise that such discussions are clearly documented in the clinical records.

Betsi Cadwaladr University Health Board - Clinical treatment outside hospital
Case reference 201404465 Report issued in July 2015
Ms A complained that over the preceding two years the Alcohol Team in the Health Board's Substance Misuse Service ("SMS") had failed to provide her with appropriate support or advice or to act on referrals including that made by her GP in 2012. Finally, Ms A expressed dissatisfaction with Betsi Cadwaladr Health Board's ("the Health Board") response to her complaint.

The Ombudsman's investigation found that there was no formal GP referral to the SMS In 2012. There was also no evidence to suggest that the SMS had repeatedly failed to act in relation to Ms A. This aspect of Ms A's complaint was not upheld.

The investigation did identify occasions when communication could have been better and to that very limited extent upheld this aspect of Ms A's complaint.

The Ombudsman recommended that the Health Board should apologise for the failings identified in the report.

Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case reference 201401141 Report issued in July 2015
Mrs X complained about the care and treatment her mother, Mrs A, received from nursing staff during her admission to hospital. Mrs X also complained that despite making an appointment to meet with Mrs A's consultant, he refused to speak to her.

The investigation found that following Mrs A's admission to hospital, there had been a failure to undertake or complete risk assessments and a care plan which placed Mrs A at risk of injury. Furthermore, during the admission there was a failure to adequately monitor Mrs A's nutritional and fluid intake despite concerns about malnourishment and hydration.

The investigation also found that an incident form had not been completed for one of the two falls Mrs A had on the ward and no further risk assessments were undertaken. Instead, Mrs A was moved to the corridor near the nurse's station.

The investigation found that there had been a failure to adequately communicate with the family when Mrs A's care changed due to her being placed on the end of life care pathway, and as a result caused added distress to the family.

Finally the investigation found that given the existing appointment, Mrs A's deteriorating condition and that there was no suggestion that he had been called away urgently, it was not reasonable for the Consultant to decline the meeting with Mrs X.

The complaint was upheld and it was recommended that the Health Board:

a) within one month, apologise to Mrs A, pay the sum of £1000 as a reflection of the identified service failure and the time and trouble Mrs A experienced in having to bring her complaint to this office and ask the Consultant to review his procedure for meeting with a patient's family;

b) within three months, remind the relevant staff of the need for full communication with relatives of people who are on the end of life pathway; the need to ensure adequate risk assessments and care plans are completed and reviewed; the need to fully complete incident reports for each incident and contact the family as soon as it is practicable; ensure that conversations with family members are documented and review any complaints that the Health Board has referred to POVA; and consider whether the matter should also be considered under PTR prior to offering redress;

c) within six months, provide the relevant nursing staff with refresher training on risk assessments, specifically in relation to falls, nutrition and hydration.

Betsi Cadwaladr University Health Board - Clinical treatment outside hospital
Case reference 201402308 - Report issued in July 2015
Mrs Y complained about the care provided to her late husband, Mr Y, by Betsi Cadwaladr Health Board ("the Health Board"). He had been suffering from severe depression and had been receiving

home treatment. The Consultant Psychiatrist ("the Consultant) responsible for Mr Y's care had an appointment with Mr Y at his home but cancelled because he was called to an emergency. Mrs Y complained that the Consultant had, on the day in question, been dismissive when she spoke with him over the telephone; unreasonably refused to speak to Mr Y on the telephone; failed to make any written medical record regarding the decision he had taken to increase medication and failed to undertake a formal mental assessment.

Mrs Y also complained that the Health Board had failed to understand the importance of Mr Y's developing delusional ideation and ignored her questions about this, and had said that it had arranged for an independent investigation of the case when in fact it was undertaken by another Consultant Psychiatrist from the Health Board.

The investigation found that there was insufficient evidence to find that the Consultant had been dismissive over the telephone; that in the circumstances it had not been unreasonable for the Consultant not to talk with Mr Y over the telephone; that the failure to make an entry in the clinical notes was maladministration; that it was not unreasonable for the Consultant, in the circumstances, not to undertake a formal assessment on the day in question; or that the Health Board failed to properly address the issue of Mr Y's condition in its complaint response and had unreasonably failed to inform Mrs Y that the reviewer appointed for her case was not an external reviewer.

The Health Board agreed to implement the following recommendations:

a) that it apologise for the failings identified by the investigation;

b) that it ensured the Consultant was reminded of record-keeping requirements;

c) that it reminded complaint handling staff they should accurately communicate to complainants the status of any reviewer assisting with an investigation.

Aneurin Bevan Health Board - Clinical treatment outside hospital
Case Number: 201405085 Report issued in July 2015

Mr G complained about the standard of care provided to his late partner, Ms F, by her GP, Dr J. He complained that Dr J did not carry out a proper assessment when Ms F presented with breathlessness. Mr G said that she should have been referred to hospital urgently. Ms F died the following day due to pulmonary embolism ("PE").

Having obtained clinical advice, the Ombudsman noted that PE was a rare and difficult diagnosis for a GP to make. He concluded that there was no clinical evidence (in accordance with NICE guidelines) to indicate immediate hospital admission. However, the GP failed to carry out a proper assessment of Ms F's condition which would have included an examination of her legs for signs of DVT (Deep Vein Thrombosis). He also did not factor in the oral contraceptive pill as a recognised increased risk factor for PE.

The Ombudsman upheld the complaint. The Ombudsman was unable to conclude that the outcome would have been different as the majority of cases of PE give no positive clinical sign of DVT. As a result of the complaint, the Practice made improvements to its processes. Dr J confirmed that the Practice now had a written protocol, based on current NICE guidance, on what to do when PE may be suspected. Dr J also agreed to apologise for the shortcomings identified in the assessment.

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case reference 201403090 – report issued in August 2015
Mr X complained about the care provided to his mother, Mrs X. She had suffered a fall, injured her hip and had been admitted to hospital. Mr X complained that there was a significant delay in diagnosing Mrs X's hip fracture and in undertaking remedial surgery. Mr X also complained about the treating consultant's unwillingness to discuss with him the care provided to his mother.

The investigation found that there was an unreasonable delay in diagnosing and operating on Mrs X's hip fracture. As a result of the delay, Mrs X's undisplaced hip fracture displaced and she underwent a partial hip replacement. Had the undisplaced fracture been discovered she could have undergone screw fixation (a simpler operation with fewer and less serious associated risks). This aspect of the complaint was upheld.

With respect to the second element of the complaint, the investigation found that the consultant was not obliged to have that discussion with Mr X, but that he was in any case not opposed to meeting with Mr X, albeit at the hospital. This aspect of the complaint was not upheld.

Aneurin Bevan University Health Board agreed to implement the following recommendations:

a)that it apologise for the failings in care and for failing to respond to an e-mail from Mr X

b)that it determined a figure based on the Putting Things Right redress arrangements to pay to Mrs X as a financial remedy

c)that it considered how lessons could be learnt from the findings of the report.

Cwm Taf University Health Board - Health - Clinical treatment in hospital
Case reference 201402540 - report issued in August 2015
Mr N complained about the inpatient care provided for his late wife, Mrs N, by Cwm Taf University Health Board ("the Health Board"). He raised concerns about the Health Board's management of Mrs N's falls risk, post fall care, oxygen therapy, swollen legs and ward moves.

The Ombudsman did not uphold those aspects of Mr N's complaint which concerned the Health Board's management of Mrs N's swollen legs and ward moves. He partly upheld the falls and oxygen therapy-related elements of the complaint. He determined that the absence of non-static nurse call bells ("Call Bells"), within the Health Board's Older Persons Mental Health Assessment

Unit ("the Unit"), might have increased Mrs N's falls risk. He confirmed that Mrs N's oxygen therapy was erroneously interrupted. He also considered that this had adversely affected her oxygen level. He recommended that the Health Board should:

a) write to Mr N to apologise for the failings identified in his investigation report

b) consider the capital funding bid made by the Mental Health Directorate for the installation of non-static Call Bells, within the Unit, alongside his investigation report

c) complete and introduce its oxygen therapy policy

d) give the Ombudsman a formal written undertaking in which it agrees to reconsider the capital funding bid cited annually if the funding requested is not awarded within six calendar months of his investigation report, until the funding requested is agreed.

Cwm Taf University Health Board - Clinical treatment in hospital
Case reference 201400079 - Report issued in August 2015

Mrs A complained about the standard of care and treatment provided to her late mother, Mrs B, at the Royal Glamorgan Hospital between March and May 2012. Mrs A was concerned that her mother was discharged on a number of occasions; that the cause of a collapse suffered by Mrs B in hospital remained unclear; whether the heart rate medication (flecainide) Mrs B was prescribed on the day of her collapse contributed to her deterioration; and that the various investigations carried out at the hospital focused on Mrs B's heart condition, rather than other potential causes. Mrs A was also concerned that there were delays and inaccuracies in the response to the family's complaint.

The Ombudsman found that while extensive and appropriate investigations were carried out by the clinicians caring for Mrs B, there were some aspects of the care and treatment which fell below appropriate standards. In particular, Mrs B should not have been discharged on one occasion; insufficient steps were taken to investigate and treat Mrs B's heart failure, and Mrs B should have been seen sooner on one occasion when she was in A&E. The Ombudsman also found that flecainide should not have been prescribed as Mrs B had heart failure, but there was no evidence that it caused Mrs B's deterioration. The Ombudsman also found that Cwm Taf University Health Board's ("the Health Board") handling of the family's complaint took too long.

The Ombudsman recommended that the Health Board should:

a) apologise to the family for the failings identified

b) pay Mrs A £1,000 to recognise the uncertainty the family have been left with due to the failure to adequately assess and treat Mrs B's heart failure, and £250 to recognise the frustration caused by the delay in responding to the complaint

c) share the report with its cardiologists and reinforce the importance of ensuring that the correct anti-arrthymic medication is prescribed for patients with heart failure.

Cardiff and Vale University HB - Clinical treatment in hospital
Case reference 201403262 – report issued in August 2015

Ms A's mother had pancreatic cancer. She died on 10 April 2014. Ms A's complaint concerned the lack of palliative care her mother received at the University Hospital of Wales ("the Hospital") towards the end of her life and especially the lack of support provided the night before her mother's death. Ms A said that her mother should have been put on a pump syringe driver to control her pain and symptoms.

The Ombudsman's investigation found shortcomings in the care Ms A's mother received which included communication failings as well as poor pain management. The Ombudsman also found that the failure by clinicians to consistently adopt a joined up approach with regards to Ms A's mother's care exacerbated the situation and contributed to the communication shortcomings that the family experienced.

The Ombudsman upheld Ms A's complaint and made the following recommendations:

a) that within one month of the final report being issued, Cardiff and Vale University UHB's ("the Health Board") Chief Executive should offer a full written apology to Ms A for the failings identified by the Ombudsman's investigation

b) within one month of this report being finalised the Health Board should pay Ms A the sum of £750 made up of £500 in recognition of the shortcomings in communication and ongoing distress caused to Ms A and £250 for Ms A's time and trouble in pursuing the complaint

c) within three months the Health Board should discuss the contents of this report at an appropriate Clinical Governance meeting and review the training provided to its staff in light of Ms A's complaint.

The partners of Oak Tree Surgery and Abertawe Bro Morgannwg University – Clinical treatment outside of hospital
Case references 201404017 & 201403754 - Report issued in August 2015

Mr P complained about Oak Tree Surgery's ("the Surgery") care of his late wife, Mrs P, over a five day period during January 2014. Consequently, both he and his wife suffered considerable distress. Mrs P was terminally ill and prescribed medications including opiates for pain relief. Following visits from two trainee GPs, during which Mrs P complained she was hallucinating and was in extreme pain, Mrs P had to ultimately be taken to hospital by Mr P. It was found she was suffering from a bowel obstruction and opiate toxicity (where the body is overloaded with drugs that it cannot expel). Mr P's complaints included that her GPs should have arranged for Mrs P's admission to hospital instead of discussing a Do Not Attempt Resuscitation (DNAR) decision with him, then leaving, and that they ought not to have prescribed certain opiates. Abertawe Bro Morgannwg University Health Board ("the Health Board") had investigated his complaint against the Surgery and Mr P was also unhappy with how his complaint was handled.

The investigation found that there were certain failings in Mrs P's care. The Ombudsman's Clinical Advisers (two experienced GPs) found that the trainee GPs failed to adequately assess Mrs P for signs of toxicity (given her presenting complaints) albeit the drugs prescribed were appropriate. They also failed to recognise Mrs P's bowel obstruction. This was a known (and reversible) complication in patients with Mrs P's condition. The discussion concerning the DNAR was inappropriate at the time and consideration should have been given to admitting Mrs P to a hospital. The Advisers questioned if the Surgery's supervision arrangements for trainees by senior colleagues was adequate. When Mr P took her to hospital it was able to reverse Mrs P's opiate toxicity and bowel obstruction. The events did not contribute to Mrs P's eventual passing some weeks later.

The Ombudsman considered that there were shortcomings in the complaints investigation undertaken and the Health Board acknowledged that this resulted in Mr P having to complain to the Ombudsman where the above failings were found. Both the Surgery and the Health Board agreed to implement all the Ombudsman's recommendations:

a) the Surgery should apologise to Mr P for the shortcomings identified

b) the Surgery should provide the Ombudsman with information concerning its supervision arrangements of trainees to ensure they were in line with professional requirements [The information subsequently provided showed that, overall, these requirements were met.]

c) that one of the trainee GPs should further reflect on Mrs P's case and discuss events at his annual appraisal

d)the Health Board should apologise to Mr P for its role in complaints handling and offer Mr P redress of £300 for his time and trouble and additional distress caused by having to pursue his complaints further.

Cwm Taf University Health Board - Clinical treatment in hospital
Case reference 201306371 - report issued in August 2015
Mrs T complained about the care and treatment she received at Prince Charles Hospital ("the Hospital") in 2012, when, during a surgical procedure that she underwent to remove a lymph node from her neck, her accessory nerve (which controls muscles in the upper back) was severed. Mrs T complained that, despite undergoing corrective nerve-graft surgery, the range of movement in her arm remained permanently restricted. Mrs T said the injury adversely impacted on her quality of life.

Mrs T also complained that clinicians at the Hospital failed to identify that the severance of the nerve had been the cause of her post-operative pain, discomfort and movement restriction and that clinicians did not fully advise her that accessory or other permanent nerve-damage was a risk of the procedure before obtaining her consent. Finally, Mrs T complained that Cwm Taf University Health Board ("the Health Board") did not adequately investigate or address all of the issues raised in her letters of complaint.

The investigation found no evidence to suggest that the severance of Mrs T's accessory nerve was caused by substandard surgical technique, or that clinicians failed to identify that the severance of the nerve had been the cause of Mrs T's post-operative pain. However, the investigation found that Mrs T was not fully advised that accessory nerve-damage was a risk of the procedure. It also found that the Health Board did not adequately investigate Mrs T's complaint since it failed to obtain an account of the events in question from the surgeon who performed the operation.

The Ombudsman recommended that:

a) the Health Board should provide Mrs T with a fulsome written apology for the shortcomings in the consent-process and for failing to investigate her complaint properly and that the Health Board makes a payment to Mrs T for the sum of £2,000

b) the Health Board should remind the Concerns Team of the need to ensure that its investigations are thorough and compliant with PTR Regulations and that formal responses to complaints are informed by evidence from the treating clinician identified by the complainant

c) the Health Board, as a matter of urgency, should confirm to this office that it has reminded all of its surgical clinicians of their duty to conduct and record pre-operative consent-processes in accordance with GMC Guidance

d) the Health Board should confirm that the Consultant Surgeon and the Surgical Registrar identified within this report have had an opportunity to reflect on its findings and conclusions.

Cardiff and Vale University LHB – Clinical treatment in hospital
Case reference 201408941 - Report issued in September 2015

Mr X complained that although he was advised that he required an operation to correct the bone following an injury to his hand, he was told in July 2013 that this was not necessary. He felt that the treatment he was given was inadequate. As a result of this, in June 2014 Mr X contacted the Consultant Orthopaedic Surgeon's secretary to try and obtain an appointment with him but was advised he needed to go back to the hospital.

Mr X also raised concerns about the behaviour of a nurse during a visit he made to the trauma clinic on 23 June 2014. He disputed Cardiff and Vale University LHB's ("the Health Board") account of events. The Ombudsman investigated the Health Board's handling of the matter.

The Ombudsman found that the deformity in Mr X's hand was a result of an old injury. The decision not to correct the injury by surgery and to provide conservative treatment was appropriate.
The Health Board also provided information about how Mr X could be seen should there be any new issues with his hand which was reasonable. The Ombudsman did not uphold Mr X's clinical complaint.

In relation to the complaint about how events on 23 June 2014 were handled, the Ombudsman found that this was not in accordance with the Health Board's violence and aggression policy ("the policy"). A warning or marker should have been placed on Mr X's records and details should have been provided to him of the complaints process and how he could challenge the decision.

The Health Board's letter also withdrew treatment from Mr X and, although this decision was subsequently amended, the letter should not have been issued in the absence of an additional breach of the policy. The Ombudsman upheld this aspect of the complaint. He recommended that the Health Board apologise to Mr X for its failure to comply with the policy.

The Health Board accepted the Ombudsman's recommendation.

Aneurin Bevan University Health Board – Clinical treatment in hospital
Case reference 201404810 - Report issued in September 2015
Mr K complained to the Ombudsman about the manner in which Aneurin Bevan University Health Board ("the Health Board") had discharged his mother, Mrs K, from Ysbyty Ystrad Fawr on two separate occasions with DVT in her leg.

Mrs K needed readmission on both occasions, but sadly died a few days after her second readmission. Mr K also complained about the Health Board's response to his complaint and the delay providing it.

The Ombudsman found that both discharges were incorrect and amounted to a service failure. That said, the Ombudsman was unable to conclude whether or not the inappropriate discharges had led to Mrs K's death because of the severity of her illness and that ultimately the fact that the cause of Mrs K's death remains unknown.

The Ombudsman also found that the Health Board's response to the complaint had been inaccurate and excessively delayed. He upheld the complaints and recommended that:

a) the Health Board should apologise and provide Mr K with redress of £500 for his time and trouble for pursuing this complaint and for the uncertainty that, if Mrs K had not been discharged from hospital, her outcome may have been different

b) in future, in cases such as this, the Health Board should ensure that its complaints responses do not rely solely on input from an individual clinician who had responsibility for the matters complained about

c) the First Consultant should have an opportunity to reflect on the statement he provided in response to the complaint

d) the Health Board should review the processes involved in investigating complaints

e) the Health Board should conduct an audit of failed discharges at YYF over the last 18 months and report its findings to the Ombudsman.

f) the Health Board should ensure that relevant clinical staff receive training on the management of anti-coagulation in patients with anaemia.

Aneurin Bevan University Health Board - Other
Case reference 201402637 - Report issued in September 2015
Mr M complained that clinicians at the Royal Gwent Hospital acted inappropriately when they instigated a child-protection investigation in respect of his daughter, K. K had been admitted to hospital with an unrelated matter in March 2014, but was noted to have a bruise behind her right ear.

Mr M complained that clinicians failed to adequately explain the child protection process, were insensitive to his family's distress, questioned K without Mr M's knowledge or permission and failed to disclose concerns that K's illness had been fabricated. Mr M said that he was made to feel as if it had been concluded that he had mistreated his daughter. Finally, Mr M complained that the Health Board's response to his complaint failed to address his concerns.

Whilst the subsequent investigation suggested that the bruise had been caused by another child at K's nursery, the Ombudsman found that clinicians had acted in accordance with child protection procedures. The Ombudsman recognised that this was an extremely distressing experience for the family, but found no evidence that clinicians had acted insensitively toward Mr and Mrs M or that there had been a failure to adequately explain the investigation process. The Ombudsman also found no evidence that clinicians were investigating concerns that K's illness had been fabricated. However, the Ombudsman did find that it was inappropriate for K to be informally questioned about the bruise by a nurse. He also found that Aneurin Bevan University Health Board's ("the Health Board") response to the complaint was insufficiently detailed.

The Ombudsman recommended that the Health Board should provide Mr M with an apology for these shortcomings.

Aneurin Bevan University Health Board – Clinical treatment in hospital
Case reference 201405743 - Report issued in September 2015
Ms A complained about the poor care she received prior to giving birth to her son. In particular, Ms A said that the failings in her care led to her being in pain and distress.

Overall, the Ombudsman's investigation found that there were shortcomings in the care Ms A received both in terms of antenatal and postnatal care. The investigation also highlighted instances when NICE guidelines were not followed which led to shortcomings in care particularly around pain management. The investigation also highlighted poor record keeping. The lack of contemporaneous record keeping meant that it was difficult to determine an accurate time line of Ms A's clinical interventions.

The Ombudsman considered that Aneurin Bevan University Health Board's ("the Health Board") response to Ms A's complaint was not in keeping with the documented clinical records and that the complaint response lacked robustness and more fundamentally did not identify the failings in Ms A's care.

The Ombudsman upheld Ms A's complaint and recommended that the Health Board should:

a) apologise to Ms A for the failings identified in this report

b) make a payment of £750 to Ms A in recognition of the shortcomings in care which were exacerbated by poor record keeping and also for poor complaint handling remind staff of their professional obligation in relation to the need to keep contemporaneous, continuous and detailed records where possible and the need to document when notes are written in retrospect

c) as part of a wider learning process this report should be discussed at an appropriate Clinical Governance meeting to consider the issues raised in this case and the learning points that arise

d) review and take action on its complaints handling process to ensure that it is fit for purpose

e) share the Ombudsman's final report with staff on the maternity ward and discuss the findings at individual team meetings.

A GP in the Betsi Cadwaladwr University Health Board area – clinical treatment in hospital
Case reference 201405271 - Report issued in September 2015
Mr Y complained about various deficiencies in the care, treatment and monitoring provided to his late father, Mr X, for his renal/kidney condition by the GP. Substantively, the complaint concerned the GP's delay in referral to, and consequent treatment, by a nephrologist/renal physician.

The investigation found that there was no written evidence in Mr X's patient notes to indicate that the GP had specifically informed Mr X in 2007 of his Chronic Kidney Disease ("CKD") diagnosis. Mr X was, however, aware that his kidney function was being monitored by the GP from the date of his confirmed diagnosis in 2008 to his death in 2013. No criticism was made of the GP's monitoring of Mr X's renal function from his diagnosis in 2007until his unconfirmed test result at the end of November 2012. At this time Mr X's result indicated that there had been a progressive deterioration in his kidney function to the extent that the reading fell below the level indicated in the NICE guidelines. At this stage NICE suggests that Mr X's test should be repeated to confirm the result, and, if confirmed the GP had discretion about whether to refer him to renal services. It was the confirmed test results on 15 May 2013 which revealed Mr X had an additional issue of a protein leak.

Both these elements together necessitate a referral to the renal physician for assessment in accordance with the NICE guidelines. Mr X was referred by the GP on 16 May 2013. The investigation found that the service failure was the GP's failure to repeat the test shortly after the reading in November 2012. The GP acknowledged that he had failed to appreciate the deterioration in Mr X's kidney function readings at this time, and as a result acknowledged the possible delay in referring Mr X to the renal team. It follows therefore that there may have been a delay in Mr X's consequent treatment for his CKD.

It was difficult to measure the injustice caused to Mr X because had the test been repeated a few weeks later, the November reading may have been higher, lower or the same. Additionally, even the November reading had been confirmed a few weeks later, NICE guidance says the GP had discretion to consider a referral for Mr X, at the most at that time. There was no definitive evidence that an earlier referral would have resulted in different treatment options being available to Mr X for his CKD. Similarly, it is considered unlikely that this had a material impact on Mr X's condition or his eventual mode of death which was from cardiovascular disease.

The investigation found that the injustice to Mr X was the uncertainty about whether the GP missed an opportunity to consider a referral to the renal team earlier than May 2013, and the uncertainty of whether Mr X's quality of life, in terms of his final months, may have been better.

The Ombudsman recommended that the amount of £750 be paid to Mr X's family in recognition of the distress and uncertainties identified in the investigation. No further recommendations were made as the GP had already acknowledged and apologised unreservedly for his failings, and he had reported the events to the Practice for a significant event review to be undertaken. As a result of this review, the Practice implemented changes for the future management and care of its patients identified with renal disease.

Other reports - Not Upheld

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case reference 201402689– Report issued in July 2015
Mr A complained about the care of his late mother, Mrs D, who underwent a routine removal of her gall bladder by laparoscopy*. Some adhesions were found in theatre (from an earlier surgery) and afterwards complications arose. It meant that Mrs D underwent three further surgeries in attempts to repair perforations to her bowel, the original of which was caused during the first procedure.

Mrs D failed to recover, suffering intestinal failure. She died almost a year later. Mr A complained that the first procedure should have been performed as an open procedure, so that the perforation would either not have happened, or would have been seen early enough for the Surgeon to have repaired it at the time. Alternatively, Mr A felt the Surgeon should have converted to an open procedure once adhesions were found, given that they compromised his view so leading to the perforation. Had this happened, Mr A considered his mother would not have died.

With advice from one of his Professional Advisers, and after putting specific questions to the Surgeon who performed Mrs D's surgery, the Ombudsman found the Surgeon to be very experienced having performed many laparoscopic procedures. His complication rate was minimal.

There was no questioning his competency. He had felt able to continue to completion without converting to an open procedure at the time. This was not outside the bounds of acceptable clinical practice in a theatre setting. Perforation during surgery is a known risk. It was listed on the consent form signed by Mrs D. The Adviser noted a flaw in the consenting process. It was not undertaken by the Surgeon himself as it should have been. However, Mrs D was known to be keen to undergo the surgery which is relatively common; there was little doubt she understood there were some risks. Whilst what happened was unforeseen, and very regrettable, and Mrs D's quality of life in her final months was extremely poor, the Ombudsman did not uphold the complaint.

*Laparoscopy is minimally invasive surgery performed through small incisions using an instrument (laparoscope). It is often called keyhole surgery and is commonly performed.

Cwm Taf University Health Board - Clinical treatment in hospital
Case reference 201405827 - Report issued in July 2015
Ms L complained about the care she received in hospital after breaking her finger. Ms L complained that the treatment she received was inadequate and delayed. Ms L said that this inadequate treatment had left her with a deformed finger which caused her pain and adversely impacted upon both her working life and her leisure pursuits. Ms L also complained about the delay on the Health Board's part in responding to her complaint, which took nearly a year to provide.

The Ombudsman found that the treatment and advice Ms L received was both appropriate and timely. He concluded that injuries such as that sustained by Ms L often left some prolonged or even permanent restriction of movement and that a full recovery may never be achieved.

Accordingly, the Ombudsman concluded that the problems Ms L was experiencing did not result from any deficit in the care she received. The Ombudsman did, however, agree that the Health Board's handling of Ms L's complaint was not timely, but concluded that, since the Health Board had already apologised for this, no further action was necessary. The Ombudsman did not uphold the complaint.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital
Case reference 201408104 Report issued in July 2015
Mrs C complained about the care given to her husband at a specialist unit of a hospital run by Abertawe Bro Morgannwg University Health Board. She said that while in the unit he suffered a fall and broke his neck in two places. She said that the fracture was not diagnosed until his re-admission to another hospital some days later.

The Ombudsman found that although Mr C had fainted, he had been sitting in a chair at the time and had not fallen. There was no evidence that he had fallen or sustained any injury while at the specialist unit, and it was not possible to determine when he sustained the fractures. He did not uphold the complaint.

Cwm Taf University Health Board - Clinical treatment in hospital
Case reference 201400712 Report issued in July 2015

Mr X was aggrieved that the suturing performed at the end of penile straightening surgery led to tethering of his foreskin. He complained that the suturing had been done poorly resulting in him later requiring a circumcision, which would not have been necessary had the wound been sutured to a reasonable standard.

The investigation found that the fact that there was evidence of tethering soon after the operation was not likely to mean that the suturing was performed to a poor and unreasonable standard. Tethering was not uncommon as a result of the procedure undertaken because of the parts of the penile anatomy which were likely to be disturbed during the procedure.

The investigation also found that the later need for a circumcision was unlikely to be linked to the suturing or the post-operative tethering.

The complaint, therefore, was not upheld.

Betsi Cadwaladr University Health Board - Appointments/admissions/discharge and transfer procedures
Case reference 201402729 – Report issued in July 2015

Ms H complained that a surgeon unfairly removed her from his waiting list for surgery. Ms H complained that her age had impacted on her treatment and that she was removed from his list because she had complained. Ms H also complained that Betsi Cadwaladr University Health Board ("the Health Board") had not adhered to the guidelines on waiting times (the Referral to Treatment – RTT – Pathway).

The Ombudsman found that Ms H's removal by the surgeon from his waiting list for surgery was a reasoned and sustainable decision, although the letter of her removal should have included guidelines for a return to the RTT pathway. However, this was explained in a letter to Ms H's GP.

There was no evidence that Ms H had been removed from the waiting list as a consequence of prejudice against her age or because she had complained. The Health Board was found to have not breached regulations in relation to her waiting time, however, it was of concern that the Health Board had failed to meet its 26 week target for treatment.

Ms H's complaint was not upheld.

Aneurin Bevan Health Board - Clinical treatment outside hospital
Case references 201401731, 201402384, 201409335 – Report issued in July 2015

Mr H's daughter, Ms G, complained that diuretics (medication to help the body get rid of excess fluid) prescribed for her father by GPs or dispensed by the pharmacy in 2011 contributed to his admission to hospital with dehydration and renal failure.

The investigation found that the GPs' prescribing of diuretics was conservative and reasonable, and did not uphold the complaint against them. However, the investigation identified that during a home visit a GP had not fully considered Mr H's particular risk of deterioration. The GP acknowledged this and set out the changes he had made in his practice since.

The evidence regarding medication dispensed by the pharmacy was limited and at times contradictory. A particular difficulty in reconciling information was the significant length of time that had passed since the events. The Ombudsman was unable to reach a finding regarding medication issued by the pharmacy.

Cardiff and Vale University Health Board - Clinical treatment outside hospital
Case reference 201406341 & 201406343 - Report issued in July 2015

Mr B's representative complained on his behalf about the standard of care provided to him by two GPs at the Practice between 8 October and 13 November 2014 when he left the Practice. He was concerned about the appropriateness of the medication he was prescribed and that the combination of medication caused him to become incapacitated and unable to function.

The Ombudsman found that whilst the combination of medication prescribed may not have been right for Mr B, this was not as a result of any shortcoming or service failure on the part of the GPs. He found that medication was prescribed in accordance with locally and nationally recognised guidelines. He did not uphold the complaint.

Cwm Taf University Health Board - Clinical treatment in hospital
Case reference 201401577 Report issued in July 2015

Miss T complained about her ante-natal care, specifically that midwives did not deal with her reports of leakage / wetness appropriately. She was also dissatisfied with her son, C's treatment since his birth. She maintains that C's breathing difficulties relate to the delay in dealing with leaking amniotic fluid before his birth. She also said that the Health Board did not carry out appropriate tests and failed to diagnose C's enlarged adenoids as a cause of his breathing problems.

The investigation found that, overall, Miss T's midwifery care and treatment was of a reasonable standard, with the exception of one ante-natal appointment. However, whilst there were shortcomings at this appointment, these did not cause Miss T or C an injustice.

Similarly, the investigation found that the care and treatment provided to C was timely and appropriate as was his referral to the Tertiary Centre for further investigations.

Cwm Taf University Health Board and a GP Practice in the Cwm Taf University Health Board area – Other
Case reference 201402977 - report issued in August 2015
Ms T complained to the Ombudsman that in 2006 psychiatric clinicians at Cwm Taf University Health Board ("the Health Board") and GPs at a practice in the Health Board area misdiagnosed her condition of High Functioning Autism/Asperger's Syndrome as Type 2 Bipolar Disorder. Ms T complained that between 2006 and 2012 she consequently received numerous referrals, treatments, medications and other therapies for a condition that she did not have.

Ms T complained that this inappropriate care and treatment exacerbated and prolonged her mental health problems and that this only became clear to her in 2014 when she received a diagnosis of Asperger's Syndrome from a private psychologist.

Ms T described how, in pursuing this complaint against her GP Practice and the Health Board, she became aware of numerous other failings and omissions in her care and treatment and in her medical records. Ms T complained that, as a result of these failings she has suffered with severe ill-health, family breakdown, loss of job, bankrupcy, social stigma, discrimination and memory loss induced by psychiatric medicines.

Following an extensive review of psychiatric and GP medical records dating back to 2006, the Ombudsman, with assistance from two clinical advisers, did not uphold Ms T's complaint. Whilst it was acknowledged that Ms T may have symptoms of High Functioning Autism, this was not considered to preclude or invalidate her diagnosis of Type 2 Bipolar Disorder.

The investigation also concluded that the care and treatment that Ms T received throughout these years from the Health Board's mental health services and from her GP Practice were reasonable and appropriate to her illness presentations.

Aneurin Bevan University Health Board Health - Clinical treatment in hospital
Case reference 201403475 - report issued in August 2015
Mr X complained about the standard of care and treatment provided to Ms X, his late partner. In October 2013, Ms X was found to have an abnormal uterus. In November, she was diagnosed with peritonitis (inflammation of the thin layer of the tissue which lines the inside of the abdomen) and associated sepsis (the body's overwhelming and life-threatening response to infection). She then underwent major abdominal surgery. An aggressive cancer was found which had spread to her lungs. In December, Ms X was readmitted with a suspected kidney infection. Various antibiotics were administered. An obstructed kidney was identified and an ureteric stent inserted to drain the kidney. The procedure was considered successful, although there was a post-procedure sepsis flare-up. Further antibiotics were administered. Ms X was discharged on 14 January. She sadly died on 30 January.

Mr X complained that the ureteric stent inserted into Ms X at the hospital was infected. He also complained that Ms X had a Clostridium difficile infection (a type of bacterial infection) and the administration of a specific antibiotic was evidence that she was suffering from that infection. He considered that one, or both, of those infections caused, or contributed to, his partner's sad death.

The investigation found that there was no evidence that a contaminated stent was used during the operation in question. There was also no evidence that Ms X was suffering from a Clostridium difficile infection and the specific antibiotic which Mr X referred to was one of four administered which, between them, would normally be effective against a range of bacterial infections. The complaint was therefore not upheld.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital
Case reference 201404885 - report issued in August 2015

Miss A complained about the treatment her father, Mr A, received at Neath Port Talbot Hospital ("the Hospital") after he suffered heart failure following total knee replacement surgery. Miss A complained that there was inadequate monitoring of his heart and that clear symptoms were ignored. Miss A complained that Mr A was prematurely discharged when he was not clinically fit.

Sadly, Mr A suffered a significant cardiac event in the Hospital's car park, shortly after being discharged, and died.

The Ombudsman found that both the overall care which Mr A received following his heart attack in the Hospital and the decision to discharge him home were appropriate. The Ombudsman concluded that the cardiac event which occurred shortly after discharge was neither foreseeable nor preventable and did not result from any deficit in care. The Ombudsman did not uphold the complaint.

Cardiff and Vale University LHB - Clinical treatment in hospital
Case reference 201404702 - Report issued August 2015

Mrs T complained about the care that her late husband had received at the University of Wales Hospital in Cardiff. Mr T had fallen and was found on admission to have broken his hip and wrist. Mr T was already in the later stages of cancer, which was spreading into bone. Conservative management of the fractures was advised and, after a few days, Mr T was discharged to a hospice, where he sadly died.

Mrs T complained that the hospital had not properly addressed the pain and confusion that Mr T experienced. She had been aware that nurses had asked for medical reviews for Mr T but said that these had not taken place promptly. She believed that treatments he received such as a blood transfusion and a pain blocking injection should have been administered earlier.

Advice was obtained from the Ombudsman's professional advisers specialising in medicine and nursing care in a hospital setting. As they believed that Mr T's symptoms had been adequately managed and that his care had not been compromised by any delay in obtaining medical reviews, the complaint was not upheld. The Board agreed to address a current absence of written guidance to staff as to how to escalate concerns.

Hywel Dda University Health Board – clinical treatment in hospital
Case reference 201502226 – Report issued in August 2015
Mrs H complained about the care and treatment that her husband received in respect of bladder cancer. Mrs H said that Hywel Dda Health Board ("the Health Board") had carried out an investigation into her complaint and it had obtained independent expert advice in clinical oncology. The Health Board accepted that there were delays and failings in the management of her husband's care and treatment but it concluded that despite those failings, her husband's cancer would have been diagnosed at or around the same time and this sadly would not have altered the course of the disease or the time of his death. Mrs H complained that she was unhappy with the findings of the Health Board's investigation.

On receipt of the complaint, it was noted that Mrs H had also written a letter to the Health Board at the time of making her complaint to the Ombudsman and, considered that it would be beneficial for Mrs H to receive a response.

The Ombudsman contacted the Health Board and it agreed to offer Mrs H a meeting with the Assistant Medical Director to explain the Health Board's response, the expert's findings and the rationale behind its decision on qualifying liability.

The Health Board agreed to contact Mrs H by 28 August 2015.

Betsi Cadwalader UHB – Clinical treatment in hospital
Case reference 201405627 - Report issued in September 2015
Mr C complained about the delay in providing pain relieving treatment to his wife. Mrs C was referred initially to the pain team in February 2014 by her GP. She saw a consultant in August 2014. He altered her pain medication and referred her for physiotherapy. She had two physiotherapy sessions. In addition, she paid for some injections privately. Invasive pain management treatment was scheduled for March 2015. Mr C complained that the wait for treatment on the NHS had been unacceptable.

The Ombudsman sought clinical advice on the complaint. The adviser noted that Mrs C did not exhibit any of the "red flag" symptoms that would indicate the need for an urgent appointment. Under current guidance, pain management injections are not a recommended treatment by NICE for non specific back pain. It is clearly desirable that patients are seen and treated as quickly as possible. It was acknowledged that the prolonged wait was regrettable but, for the reasons above, it did not represent a failure in adequate clinical assessment or care. The Ombudsman did not uphold the complaint.

Powys Teaching LHB – Continuing Healthcare
Case reference 201408800 - Report issued in September 2015
Mr X complained about Powys Teaching LHB's ("the Health Board") consideration of his retrospective claim for NHS funded continuing healthcare (CHC) for his late mother.

The Ombudsman found that the Health Board had followed the procedure set out in Welsh Government guidance; had considered all the available evidence; and had applied the relevant tests in reaching its decision that Mrs X was not eligible for CHC, other than for the period it awarded. As there was no evidence of maladministration in the Health Board's consideration of the claim, the Ombudsman did not uphold the complaint.

Betsi Cadwaladr University Health Board – Clinical treatment outside hospital
Case reference 201404246 - Report issued in September 2015
Mrs A complained about the support provided to her by a Psychiatrist and Psychologist from August 2012 to May 2013.

The Ombudsman found that the actions of the Psychologist were in line with acceptable practice. In relation to the treatment given by the Psychiatrist, the Ombudsman had some concerns about her decision to prescribe Mrs A quetiapine (an anti-psychotic) when the clinical evidence suggested that alternatives such as an antidepressant, or therapy, may have been more appropriate in this case. However, as Mrs A did not in the event take the quetiapine, and her mental health improved, she did not suffer any injustice from this. The Ombudsman did not uphold the complaints.

Quick fixes & voluntary settlements

Cardiff and Vale University LHB - Medical records/standards of record-keeping
Case reference 201502003 – Report issued in July 2015
Mrs S complained that Cardiff and Vale University LHB ("the Health Board") failed to ensure that her patient rights were upheld by providing information in a timely manner. She complained also that there were a number of factual errors in a Rights Form completed during her admission and one in the complaint response provided by the Health Board. Finally Mrs S complained that the original investigation failed to examine all available information.

Having considered the complaint it appeared that the aspects of the complaint relating to some of the factual errors had not been raised with the Health Board previously. Further, it was noted that although the Health Board attempted to resolve Mrs S's concerns about the provision of the information concerning her rights follow up information relating to agreed actions had not been provided.

The Health Board agreed to:

a) investigate and respond to Mrs S's concerns about the factual inaccuracies

b) provide Mrs S with details of the outcomes arising from the agreed action points.

Cardiff and Vale University LHB - Non-medical services – food, cleanliness etc.
Case reference 201501722 – Report issued in July 2015
Ms A complained about Cardiff and Vale University LHB's ("the Health Board") refusal to fund her

travel expenses for treatment outside of Wales. On receipt of her complaint, the Ombudsman contacted the Health Board and it agreed to assist Ms A with her travel expenses.

Hywel Dda University Health Board - Clinical treatment in hospital
Case reference 201408672 – Report issued in July 2015
Mrs M complained about the care and treatment that her husband received after being admitted to Glangwili Hospital, for a pre-arranged operation. Despite various surgical interventions, Mr M's condition deteriorated. Mrs M raised her concerns with Hywel Dda University Health Board ("the Health Board") about poor communication and the lack of information that was provided to her family about her husband's care and condition; matters relating to a tracheotomy and ventilation; and the reluctance and delay caused by the Health Board in providing information about her husband's treatment. Mrs M complained to the Ombudsman that the Health Board had failed to provide a satisfactory response to her concerns.

Following consideration of the complaint, the Investigating Officer contacted the Health Board to discuss Mrs M's concerns. The Health Board agreed to carry out the following actions by 18 August 2015:

a) to provide a written apology for the delay in providing the full medical notes; the difficulties that Mrs M experienced in accessing information; and the delay in responding to Mrs M's letter dated 18 December 2014

b) to provide a written explanation to address Mrs M's concerns about MRSA; Mr M's palliative and end of life care; and the Health Board's decision to transfer Mr M from ICU to HDU.

Cardiff and Vale University Health Board - Continuing care
Case reference 201500870– Report issued in July 2015
Mrs A's solicitors complained on her behalf about Cardiff and Vale University Health Board's ("the Health Board") refusal to convene an Independent Review Panel on the basis that its decision contravened the Continuing NHS Healthcare National Framework, May 2010 and that her mother's needs could not be described as falling "well outside the eligibility criteria".

On receipt of the complaint, the Ombudsman's office contacted the Health Board who subsequently agreed to convene an Independent Review Panel to consider the original decision that the patient did not meet the eligibility criteria for NHS Funded Continuing Healthcare. The Ombudsman considered that this action was reasonable in order to settle the complaint and closed the file on that basis.

Aneurin Bevan University Health Board - Other
Case reference 201408747 - Report issued in July 2015
Mr and Mrs A complained about Aneurin Bevan University Health Board's ("the Health Board") failure to provide a care service to their adult son, B, as detailed in his care plan, over a number of months. The Health Board acknowledged that it had not provided the agreed number of care hours. This had been because of the specialised nature of the care required and it had now arranged for a private agency to provide this service.

The Health Board agreed to:

a) apologise in writing to Mr and Mrs A

b) ensure that the service was provided, as detailed in the care plan

c) arrange for a single point of contact between Mr and Mrs A and the Health Board to raise any future concerns, in order to promote positive communication with the family in the future

d) make a payment of £2100 in recognition of the failure to provide the assessed service.

Betsi Cadwaladr University Health Board – Other
Case reference 201403077 - Report issued in July 2015

Ms A was referred by her dentist to a Dental Hospital in England after unsuccessful root canal treatment. Both Ms A and her dentist were dissatisfied with the Dental Hospital's subsequent decision on her management. Ms A complained to Betsi Cadwaladr University Health Board ("the Health Board"). She made the Health Board aware that given the deterioration in her tooth she had made an appointment to see a private dental practitioner, although she was concerned about the costs. Ms A was dissatisfied with the way that the Health Board dealt with her complaint and the delay in her receiving a response.

The Ombudsman found that there had been failings in the Health Board's complaint handling. He also found that the Health Board had failed to advise Ms A of her right to seek a second NHS opinion. Given this he reached a settlement with the Health Board the terms of which were as follows:

a) That the Health Board make a payment of £595 to Ms A. This was to reflect firstly the failings in complaint handling and secondly, the loss of opportunity that Ms A suffered as a result of the Health Board's failure to notify her that a NHS referral for a second opinion was an option open to her.

b) That the Health Board reminds staff of the importance of record keeping particularly when handling complaints.

Powys Teaching Health Board - Continuing care
Case reference 201406283 - report issued in August 2015

The complainant's solicitors complained about how the review of retrospective eligibility for NHS Funded Continuing Healthcare (in respect of the complainant's late father) was undertaken. An Independent Review Panel ("the Panel") had been convened to consider the case. The complainant was of the view that the Panel's consideration of the claim was flawed.

Having been provided with clinical advice which suggested that there was evidence that the decision taken by Panel may not have been robust, the Ombudsman asked Powys Teaching Health Board ("the Health Board") whether it would be prepared to arrange for another Panel to be undertaken. The Health Board agreed to do so. The Ombudsman, therefore, considered the complaint to be resolved.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital
Case reference 201501673 - report issued in August 2015
Mrs X complained that Abertawe Bro Morgannwg University Health Board ("the Health Board") had failed to fully address her concerns with regard to the timeliness of her cancer diagnosis and the appropriateness of her subsequent treatment between November 2011 and December 2012. She raised concerns that the Health Board had declined her request to instruct a clinical expert to assess her outstanding questions.

The Health Board agreed to:

a) commission an external expert to provide an independent opinion on the care and treatment provided to Mrs X

b) reopen its investigation into Mrs X's complaint to examine Mrs X's outstanding questions

c) commission a joint breach of duty and causation report, in accordance with Part 6 of the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011

Cardiff and Vale University Health Board - Clinical treatment in hospital
Case reference 201400763 – report issued in August 2015
Ms X complained about the standard of treatment provided to her late mother, Mrs Y. The specific complaints that the Ombudsman investigated were that:

• a capacity assessment for Lasting Power of Attorney and making a will was not carried out properly
• the level of medication given to Mrs Y was excessive
• an allegation that Mrs Y had made against staff should have been dealt with under POVA
• Cardiff and Vale University Health Board ("the Health Board") had referred her concerns about Mrs Y's capacity to make a will to its Legal Department and she had not received a response on this point

Having obtained clinical advice on the complaint, the Ombudsman concluded that the capacity assessment and the medication prescribed were both reasonable. He therefore did not uphold these aspects of the complaint. The Health Board recognised that, with hindsight, it would have been good practice to make a POVA referral in relation to the allegation made against staff.

Finally, the Ombudsman found that the Health Board's response to Ms X's complaint about the capacity assessment was unreasonably delayed. He upheld this aspect of the complaint.

Aneurin Bevan University Health Board - Continuing care
Case reference 201501031 – report issued in August 2015
Mr X complained that Aneurin Bevan University Health Board ("the Health Board") had applied the wrong rate of interest when calculating his late aunt's retrospective claim for NHS Continuing Healthcare. Mr X said that the Health Board had placed his late aunt's estate at a detriment by using the retail price index rather than the county court rate of interest.

Having examined the details of the complaint, the Ombudsman contacted the Health Board and it agreed to consider the matter further taking into account the guidance outlined in Welsh Health Circular 2015/039. The Health Board also agreed to contact Mr X directly to request any additional information that it may require.

A Dentist in the area of Betsi Cadwaladr University Health Board - Clinical treatment outside hospital
Case reference 201501991 – report issued in August 2015
Mr X complained that the dentures provided to him were not fit for purpose. Mr X also said he was not advised that the payment he made in May 2014 covered a maximum period of 12 months and was not for the full course of treatment. Mr X did not think he should be charged for a new set of dentures as advised by the dentist in these circumstances.

The Dentist examined Mr X's teeth and advised that he needed a full extraction in May 2014. Impressions were completed and a set of dentures made. Mr X said that he paid for the treatment at the time. Mr X was referred to hospital for the extractions to be undertaken due to his fear of dental treatment.

It took until May 2015 for the extractions to be completed and by the time Mr X returned to the Dentist, the dentures did not fit properly. The Dentist adjusted the upper set but could not correct the lower set. Mr X said that he was told that he would require new dentures and that this would incur a charge.

Mr X complained to the Dentist and later to the Ombudsman and said that the dentures provided were not fit for purpose. Mr X also said he was not advised that the payment he made in May 2014 covered a maximum period of 12 months and was not for the full course of treatment. The Dentist also provided the Ombudsman with an account of what he considered had taken place.
The Dentist agreed to settle this complaint and offered a full refund of the fees that Mr X paid for the dentures in 2014. The Ombudsman was of the view that this was a reasonable settlement.

Aneurin Bevan University Health Board - Appointments/admissions/discharge and transfer procedures
Case reference 201501486 – report issued in August 2015
Mrs X had previously complained to Aneurin Bevan University Health Board ("the Health Board") about the care and treatment that her mother had received and was dissatisfied with its response.

Mrs X's mother had been given a diagnosis of cancer and told she had limited time to live. It was however later identified that the diagnosis had been incorrect. Mrs X said that her mother's health deteriorated following this and that she was given no psychological support. Mrs X said that the extent of the deterioration over the following months coupled with her caring duties impacted on the timing of the complaint being submitted.

The Health Board considered the complaint to be 'out of time' and said that it would not be able to consider the issues raised. The Health Board's response however said that there had been no breach in its duty of care without a full explanation of what had taken place.

The Health Board agreed with the Ombudsman to review its findings and response to the complaint in light of Mrs X's comments.

Hywel Dda University Health Board- Health - Clinical treatment outside hospital
Case reference 201409337 – report issued in August 2015

Ms A complained to Hywel Dda University Health Board ("the Health Board") about the poor care and treatment she had received from her GP. She was unhappy that the Health Board's complaint response was confined to thanking her for bringing the complaint to its attention. She complained to the Ombudsman about the Health Board's handling of her complaint.

The Ombudsman's investigation found that the Health Board had failed to inform Ms A in writing that it had passed Ms A's complaint to her GP Practice who had agreed to investigate the complaint and respond directly to Ms A.

The Health Board agreed to settle the complaint on the following terms:

a) it would apologise to Ms A for its poor communication and the consequent confusion and distress this had caused and would offer a sum of £150 in recognition of this

b) it would offer to meet with Ms A so that it could discuss the circumstances of her case.

Hywel Dda University Health Board – Clinical treatment in hospital
Case reference 201502689 - Report issued in August 2015

Mrs C contacted the Ombudsman to complain about the time is had taken for Hywel Dda Health Board ("the Health Board") to provide her with a response to her concerns raised.

On receipt of Mrs C's concerns, the Ombudsman's office contacted the Health Board and it was agreed that the Health Board would:

a) offer a meeting with Mrs C to explain the difficulties it has had in preparing a thorough response

b) offer a sum of £250 in recognition of the delays in providing her with a response.

Crescent Dental Care Centre, Swansea – Clinical treatment outside of hospital
Case reference 201502512 – Report issued in August 2015
Mr D complained that he was allocated a Dentist without prior consultation of his appointment on 10 September 2014 and should have been provided with a choice. He further complained that the Centre mishandled his initial complaint regarding his treatment. He also complained about the process taken by the Centre to de-register him from its care. He also requested the return of his dental/medical records by the Centre.

The investigation discovered that the Centre had not had an opportunity to respond to the issues raised by Mr D. The Centre agreed to write to Mr D within 20 working days of the date of this summary, responding to each of the four issues raised by him in his complaint.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital
Case reference 201502880 – Report issued in August 2015
Mr X's complaint to the Ombudsman concerned the initial delay by Abertawe Bro Morgannwg University Health Board ("the Health Board") in providing a full response to the above issues after raising concerns with the Health Board in May 2015 about the progression of cancer despite receiving regular PSA tests. Mr X also raised concerns about the method of informing him of the diagnosis.

On receipt of the complaint, the Ombudsman's office contacted the Health Board which agreed to provide a full response by 1 September 2015.

Dudley Taylor Pharmacies Ltd – Clinical treatment outside of hospital
Case reference 201501275 – Report issued in August 2015
Mr A complained about an incident on 9 April 2015 when a prescription for Ibuprofen was dispensed with incorrect directions amounting to a dose that was not within an acceptable range of prescribing. He was admitted to hospital the following evening with symptoms of dizziness, imbalance and vomiting. Following a five day hospital admission, Mr A's symptoms had not fully resolved. He alleged that his symptoms were caused by the excessive dose of Ibuprofen.

A Professional Adviser to the Ombudsman said that it was not possible to determine with any certainty whether Mr A's symptoms were caused by the excessive dose of Ibuprofen taken. The Pharmacy had already thoroughly investigated the incident and had offered Mr A a sincere apology for the service failure identified. As it had also provided Mr A with written assurances that robust methods were in place to prevent such a situation from occurring again, there was little further to be achieved through an investigation of his complaint.

However, the Ombudsman contacted the Pharmacy and it agreed to pay Mr A the sum of £500 in recognition of its error and the doubt arising about the cause of his subsequent symptoms.

Cardiff and Vale UHB – Clinical treatment in hospital
Case reference 201502061 - Report issued in August 2015
Mr W complained about the time taken by Cardiff and Vale University LHB ("the Health Board") to respond to his complaints about the Dental Hospital. In addition, Mr W complained about a number of general matters relating to the service provided and concerns about the process and information provided to patients. In the context of treatment provided to him, Mr W complained that he was not formally asked to consent to treatment by student dentists, was not advised when his treatment programme changed and experienced a nine month delay between appointments.

Having considered the complaint and the responses provided by the Health Board it appeared that some aspects had not been adequately explained by the Health Board. The Health Board agree to provide further explanation to Mr W in respect of:

a) the delay in the provision of substantive complaint response

b) consent to treatment by student dentists

c) transfer of treatment programme

d) delay during treatment period

e) the target times applicable.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201501537 – Report issued in September 2015
Mrs X complained that Betsi Cadwaladr University Health Board ("the Health Board") had recorded information in her daughter's Child Health Record ("the record") in relation to her health and mental health status which was incorrect. This incorrect information was then reproduced in a report submitted to a Child Protection Panel and Mrs X said that as a consequence of this incorrect information her daughter was placed on the child protection register. The Health Board had previously refused to amend the record to Mrs X's satisfaction.

Having considered the complaint and responses provided by the Health Board it appeared that some aspects of Mrs X's complaint had not been appropriately dealt with by the Health Board. The Health Board agreed to the following proposals for early resolution of this complaint:

a) note Mrs X's disagreement with the references to her mental health in the record

b) to update the record to reflect her current health status, if necessary;

c) submit an addendum report to the Child Protection Panel which accurately reflects her current health and mental health status so that this may be considered in a forthcoming appeal hearing

d) to provide Mrs X with relevant forms to enable her to access her mental health records.

Cardiff and Vale University Health Board - Health - Clinical treatment in hospital
Case reference: 201503008 – Report issued in September 2015

Mr W complained about the response received from Cardiff and Vale University LHB ("the Health Board") to concerns he raised about dental treatment provided at the Dental Teaching Unit. Mr W was concerned that he was not advised that he was to be treated as part of a postgraduate programme and did not specifically consent to treatment by postgraduate students.

Having considered the complaint and responses provided by the Health Board it appeared that some aspects had not been adequately explained by the Health Board. The Health Board agreed to provide further explanation to Mr W in respect of:

a) consent to treatment by student dentists

b) information about the treatment programme.

Aneurin Bevan University Health Board – Clinical treatment in hospital
Case reference: 201501652 – Report issued in September 2015

Mr & Mrs A complained about the quality of assessments that were undertaken of their son by the Child and Adolescent Mental Health Service ("CAMHS"), following an 18 months wait to establish whether he fitted the criteria to receive a diagnosis of Autistic Spectrum Disorder ("ASD"). Mr & Mrs A asked for a second opinion in light of these concerns.

On receipt of Mr & Mrs A's complaint, the Ombudsman contacted the Health Board and suggested that there was action it might take to resolve the matter quickly. The Health Board agreed to undertake the following in settlement of the complaint:

a) apologise to Mr & Mrs A for the failings identified in this case

b) deem the report on their son's assessment to be invalid

c) share the Ombudsman's concerns about inappropriate comments within the report with CAHMS staff

d) offer their son an urgent second opinion with regard to a diagnosis for ASD, and

e) collate all available assessments of their son to provide a global assessment of his needs.

Cardiff and Vale University Health Board - Health - Non-medical services
Case reference: 201502551 – Report issued in September 2015

Following the sudden death of Miss A's teenage son, a post-mortem was carried out at the University Hospital of Wales during which tissue samples were retained. Miss A complained that the Health Board failed to make the retained samples available for her son's cremation. She also said that there was a significant delay before the remains were entrusted to her and she was distressed

by the handover which took place in the public concourse at the University Hospital.
On receipt of the complaint, the Ombudsman contacted the Health Board to suggest that there was action it could take to resolve the matter. In settlement of the complaint the Health Board agreed to pay Miss A £1,100 in recognition of the distress caused by its failure to return her son's remains in a timely and fitting manner and to provide funds so that they may be cremated.

Cwm Taf University Health Board - Health - Clinical treatment in hospital
Case reference 201501846 – Report issued in September 2015
The complaint relates to the treatment received by Mrs X at the Royal Glamorgan Hospital. After raising concerns with Cwm Taf University Health Board ("the Health Board"), the response raised further concerns as the Health Board refused to accept the complaint should enter Part 6 of the Regulations.

On receipt of the complaint, the Ombudsman contacted the Health Board which agreed to enter Part 6 of the Regulations. They agreed to send the response by 24 September 2015.

Betsi Cadwaladr University Health Board – Health - Clinical treatment in hospital
Case reference: 201502859 – Report issued in September 2015
Mrs F complained about the delay in the administration and the lack of communication that she received from Betsi Cadwaladr University Health Board ("the Health Board") following a Protection of Vulnerable Adults investigation in relation to the care that her mother received at Deeside Community Hospital.

On receipt of the complaint, the Investigation Officer contacted the Health Board to discuss the concerns raised by Mrs F. The Health Board explained that it had received a copy of Mrs F's letter which outlined her concerns. The Health Board explained that it had concluded its investigation and it was therefore in the process of preparing its final response. Taking this into account, the Investigation Officer considered it was appropriate to allow the Health Board to finalise its response to Mrs F in order that it could address her concerns.

The Health Board agreed that it would send its written response to Mrs F no later than 22 October 2015.

Betsi Cadwaladr University Health Board – Health - Medical records/standards of record-keeping
Case reference 201502396 – Report issued in September 2015
The complainant Mrs T was unhappy that an entry placed on her son's medical record by a Doctor employed by Betsi Cadwaladr University Health Board ("the Health Board"). She believed that the entry did not reflect the fact that the son had been removed from Children and Adolescent Mental Health Services (CAHMS) intervention as a result of him seeing an independent Doctor who had diagnosed that he had psychological problems. She believed that the entry suggested that she and her partner had taken the decision to remove him from the CAHMS programme.

The investigation found that there was clearly a dispute between the Doctor and the complainant in relation to what had occurred. The Ombudsman recommended that the Board should:

a) attach a note to her son's medical record stating that the complainant disputes the comment, made by the Doctor concerned, in relation to the cessation of his CAHMS intervention

b) send a copy of the amended record to the complainant within 20 working days of the date of this letter.

Cwm Taf University Health Board - Health - Clinical treatment in hospital
Case reference: 201503150 – September 2015
Ms S complained to the Ombudsman that she made a complaint to the Health Board in July 2014; however, Cwm Taf University Health Board ("the Health Board") had failed to provide her with a response.

The Ombudsman contacted the Health Board to establish its position. The Health Board advised that the final response had been drafted and would be sent within 5 working days. Given the unreasonable delay the Health Board agreed to:

a) offer an apology for the delay in responding

b) offer a sum of £300 for the time and trouble in raising a complaint.

Abertawe Bro Morgannwg University Health Board -Appointments/admissions/discharge and transfer procedures
Case reference 201502237 - Report issued in September 2015
Ms D complained that she was advised she would need to wait nine months for an appointment to treat damage to her eardrum and subsequent hearing loss. As the hearing loss affected her ability to work and she was concerned about the length of time it would take to have an appointment she purchased a hearing aid.

Ms D was seen within the 26 week referral to treatment waiting time, but Abertawe Bro Morgannwg University Health Board acknowledged it had advised her that the wait would be longer and this may have contributed to her decision to seek private treatment. It therefore agreed to pay Ms D £250 in recognition of the time and trouble pursuing the complaint and any distress caused. Ms D agreed this would settle her complaint.

Aneurin Bevan University Health Board – Clinical treatment in hospital
Case reference 201403526 - Report issued in September 2015
Mrs B complained that the psychiatric assessment that her husband, Mr B, received following his emergency admission to Neville Hall Hospital in a state of psychological crisis, wrongly concluded that he was not at risk of self-harm and was safe to be discharged. Mrs B said that on the same

day that Mr B was discharged he attempted to take his own life. Mrs B complained that, in spite of this, Aneurin Bevan University Health Board ("the Health Board") maintained that the assessment had been "clinically appropriate" and that the doctor who completed it was "correct" in concluding that there was a low risk of self harm.

Mrs B also complained that, on the night in question, the Health Board's attempts to provide Mr B with emergency psychiatric care and treatment in an appropriate clinical environment were confused and chaotic; that the assessment was brief and took approximately 20 minutes to complete; that the start time of time of the assessment had been retrospectively amended by a junior doctor and, finally, that the Health Board's complaint response contained a confused and contradictory account of the time and duration of the assessment.

The Ombudsman found shortcomings in the way that Mr B's risk assessment was conducted, but could not conclude that a more detailed and optimal risk assessment would have identified suicidal intent on the part of Mr B. The Ombudsman also found that the Health Board's complaint response was confusing in regard to the duration of the assessment and that there were failings in the availability of out of hours facilities for Mr B's emergency psychiatric care.

The Ombudsman recommended that the Health Board should:

a) provide Mr and Mrs B with a fulsome written apology for the shortcomings in the psychiatric assessment identified in this report and for the "communication breakdown" in which it was not clear where Mr B was to receive emergency psychiatric care.

b) make a payment to Mr B in the sum of £500 in recognition of the injustice arising from the identified failings and a further £150 in recognition of the time, trouble and inconvenience that was entailed in Mrs B pursuing her complaint about these matters

c) remind the Concerns Team of the need to ensure that its investigations are thorough and informed, at the earliest opportunity, by evidence from the treating clinician identified by the complainant

d) ensure that its medical directorate considers, with the clinical tutor, the scope for enhancing the training of junior liaison psychiatry doctors assessing patients in the A&E Department

e) provide the Ombudsman with a written update detailing progress made in the ongoing redesign of Gwent-based, out of hours, mental health services.

Cardiff and Vale University LHB – Clinical treatment in hospital
Case reference - Report issued in September 2015

Mr X raised concerns about the care and treatment of his late wife by Cardiff and Vale University Health Board ("the Health Board").

The Health Board provided Mr X with a response to his complaint in March 2015; however he remained dissatisfied as it had failed to address his concerns in full. The Health Board agreed to address Mr X's outstanding concerns and provide him with a written response within 30 working days.

Powys Teaching LHB – Continuing healthcare
Case reference 201403580 – Report issued in September 2015
Mr A's Solicitors complained on his behalf about deficiencies in the Continuing NHS Healthcare ("CHC") process and the way that the Independent Review Panel ("Panel") had considered Mr A's claim for retrospective CHC in relation to his late mother.

The Ombudsman's investigation established that there had been shortcomings in the CHC process. Given this, Powys Teaching LHB ("the Health Board") agreed to settle the complaint on the following terms:

a) where CHC eligibility had not been found the CHC process would be started again with a fresh Clinical Adviser who should take into account the concerns that the Ombudsman's Professional Adviser had raised

b) in the event that a Panel was held to consider the Clinical Adviser's recommendations, the Health Board would liaise with Mr A's Solicitors about the composition of a freshly constituted Panel and whether it contained some of the original Panel members or Panel members not previously involved in the case. In addition, a Panel would be provided with a copy of the advice from the Ombudsman's Professional Adviser.

Complaint-handling

Upheld

Abertawe Bro Morgannwg University Health Board area - Health
Case Number: 201404402 – Report issued in July 2015
Ms X complained that the Practice's receptionist publicly discussed her medication and that she was unfairly removed from the Practice list. The Practice accepted that issues of confidentiality may have been discussed in what is a very open area, and apologised if this had indeed happened. The complaint in relation to the breach of confidentiality was upheld. As the Practice had apologised and staff were to be highlighted the issue of confidentiality arising from this complaint, no recommendations were made.

It was not considered that the Practice could be construed as having removed Ms X from their list. This aspect of the complaint was not upheld.

Betsi Cadwaladr University Health Board - Health
Case reference 201502694 - Report issued in August 2015
Mrs C contacted the Ombudsman to complain that Betsi Cadwaladr University Health Board ("the Health Board") had failed to respond to her concerns, or acknowledge a letter sent by her dated 27 April 2015.

On receipt of Mrs C's concern, the Ombudsman's office contacted the Health Board and asked what its position was in considering Mrs C's concerns. It informed the Ombudsman that it had received Mrs C's letter. However, it agreed that there was a failing to acknowledge receipt of the correspondence and that there was a delay in providing a full response, due to the Health Board awaiting confirmation from a GP.

It was agreed that the Health Board would:

a) Respond to Mrs C by 27 August 2015

b) Offer a redress payment for time and trouble

CAFCASS Cymru – Various other
Case reference 201408442 - Report issued in August 2015
Ms D complained that CAFCASS Cymru did not appropriately investigate a complaint she made about the release of confidential information relating to her family by a member of its staff to an external body. Ms D said that the member of staff was asked to hold personal information relating to her family in confidence but failed to do so. Ms D referred this matter to CAFCASS Cymru together with a number of unrelated complaints.

CAFCASS Cymru investigated the issue but failed to reach definitive conclusion on the matter. Ms D complained that the matter was not thoroughly investigated.

The Ombudsman's investigation found that CAFCASS Cymru's investigation of this issue was confined to consideration of the case files and a discussion with the member of staff concerned. No third party enquiries were made. The investigation identified that CAFCASS Cymru's complaints procedure and guidance did not specifically preclude the making of third party enquiries, although this was not common practice. The investigation concluded that, to provide reassurance that a meaningful investigation had been undertaken, third party enquiries should have been made and that this may have resulted in a definitive conclusion on this particular issue.

Ms D's complaint was upheld and CAFCASS Cymru agreed to the following recommendations:

a) that it would apologise to Ms D

b) that it would review and amend its Guide to Complaints and internal Complaint Handling Procedure.

Not Upheld

Torfaen County Borough Council - Various other
Case reference 201500830 – Report issued in August 2015
Mr D complained that a Social Worker made inappropriate comments and that his complaint about this issue had not been addressed by Torfaen County Borough Council ("the Council"). It was not possible to make a finding in respect of the first part of the complaint as the investigation did not establish with certainty that the Social Worker had made the comments attributed to her.
The second part of the complaint that Council did not investigate the complaint about the Social Worker, in line with its complaints policy, was upheld.

The Council has since replaced the Social Worker on the case, as it was apparent that the working relationship between the parties had broken down. Therefore, no further action by the Council was necessary; it had already taken appropriate action to remedy any potential injustice to the complainant.

Quick fixes & voluntary settlements

Hywel Dda University Health Board - Health
Case Number: 201501351 – Report issued in July 2015
Mrs R complained that she had not received a final response after making her original complaint to the Health Board in May 2014 regarding the care of her late father. On receipt of the complaint, the Health Board were contacted and agreed to provide a full response by 7 August 2015.

Hywel Dda University Health Board - Health
Case reference 201501305 – Report issued in July 2015

Mrs J complained about the care and treatment that her mother received at Glangwili General Hospital. Mrs J said that her mother sustained a fall at home, but it took three hours before an ambulance arrived to take her mother to hospital. Also that on arrival at hospital, Hywel Dda University Health Board ("the Health Board") took several hours before it carried out an X-ray, or provided pain relief to her. Mrs J complained to the Health Board in November 2014 and she was advised that the Health Board would carry out an investigation into her concerns. However, in March 2015, the Health Board further explained that it anticipated that the investigation would take between three to six months to complete. Mrs J complained to the Ombudsman that the Health Board failed to provide its response to her complaint.

Following consideration of the complaint, the Investigating Officer contacted the Health Board to discuss Mrs J's concerns. The Investigating Officer asked the Health Board to provide its full written response to the complaint and to apologise for the delay in providing the response within ten working days.

The Health Board agreed to carry out the requested action.

Aneurin Bevan University Health Board - Health
Case reference 201500895 – Report issued in July 2015

Mrs D complained that her late husband did not receive adequate treatment after he was admitted to the Royal Gwent Hospital on 25 August 2014. She stated that he was not correctly fitted with an intravenous feed until 27 August 2014. She also stated that he was not given any of his prescribed medicine whilst at the Hospital. She was also concerned at the length of time the Board had taken to respond to her complaint.

The investigation found that Mrs D had not been given the opportunity to meet with relevant staff involved in her late husband's treatment.

It was recommended that:

a) the complainant should be contacted within 10 working days of the date of this letter to arrange a meeting

b) a mutually acceptable date be set up meeting be set up within 20 working days of the date of this letter.

The Board has already contacted Mrs D to arrange an appropriate date for a meeting.

Caerphilly County Borough Council - Housing
Case reference 201501999 – Report issued in July 2015

Mrs C complained that on 15 December 2014 she contacted Caerphilly County Borough Council ("the Council") to report an electrical fault and was given a time slot for an emergency call out. Mrs C says no one called and she was at her property during the time slot given (4:30pm-6:30pm). Mrs C says she received a letter in February 2015, from the Council, stating that she was being re-charged for the call out and the re-charge would be £86.88. Mrs C disputed this charge and the Council referred the matter to a debt collecting agency.

Further to this information being forwarded to the Ombudsman, the Council agreed and informed him that it had 'reassessed its practices and changed its procedure'. It also stated that the 'operatives had been advised to call the Central Repairs Team/Out of Hours team if they do not get an answer and the central team will attempt to make contact with the tenant to advise them the operative is at their property. Details from these calls will be added to the record for future reference'.

In light of this, the Council had agreed to withdraw the re-charge of £86.88 as its 'no access procedure' at the time did not provide sufficient evidence to substantiate the charge. The Council will write to Mrs C shortly to inform her of this decision along with an apology for any inconvenience this matter may have caused her.

Conwy County Borough Council - Children's Social Services
Case reference 201501803 - Report issued in July 2015
Mr and Mrs V complained that Conwy County Borough Council ("the Council") had refused to accept their complaint at stage two of the Social Services complaints procedure and had instead advised them of an appeal route. When they attempted to take the appeal route they were advised that they did not have the right of appeal.

In order to establish the correct approach in this case, the Council agreed to meet with the complainants to give them an opportunity to provide further detail about their complaint. Following this meeting the matter may either be referred to the safeguarding panel to address or considered at stage two of the Social Services complaints procedure.

Hywel Dda University Health Board - Health
Case reference 201502108 - Report issued in August 2015
Ms E complained that Hywel Dda University Health Board ("the Health Board") did not have a suitably robust system of managing complaints. She said that she initially raised a complaint with the Health Board in October 2014 but to date had not received its response.

On receipt of this complaint the Ombudsman's office contacted the Health Board which agreed to the following terms:

a) provide Ms E with an explanation for the delays and failures to respond to her

b) provide Ms E with a written response by 28 August 2015

c) offer Ms E a monetary sum for redress in recognition of its failures to respond in a reasonable time

d) provide the Ombudsman with a summary of steps it has taken or plans to take to stop the chances of this happening to others.

Pembrokeshire County Council - Complaints Handling - Various Other
Case reference 201502425 – Report issued in September 2015
Mr A complained through the Citizen's Advice Bureau ("CAB") about an item he had purchased. The complaint was classified as being of a civil (and not criminal) nature, and was therefore not forwarded to the Council's Trading Standards department. Mr A was unhappy that the Council stated that the decision to classify the complaint as a civil matter was due to information supplied by him to CAB during the initial phone call, which he felt amounted to a false allegation against him. He was also unhappy that the Council did not then further process his complaint in line with its relevant procedures.

The Ombudsman agreed that there were some issues with the handling of the complaint and asked the Council to apologise to Mr A for any distress caused.

Betsi Cadwaladr University Health Board - Complaints Handling – Health
Case reference 201502076 – Report issued in September 2015
Mrs X complained that it had been more than 14 months since first registering her concerns with Betsi Cadwaladr University Health Board ("the Health Board") regarding the treatment her late husband received in November 2013. Mrs X found the experience incredibly distressing, which was compounded by the excessive delays.

The Health Board agreed to provide Mrs X with an apology for the delay to date. It also agreed to provide Mrs X with £250 for the delays and inadequacy of the update information provided.

Education

Not Upheld

Neath Port Talbot County Borough Council – Exclusions
Case reference 201406335 - Report issued in August 2015
Mr B complained about the decision of an Independent Appeal Panel ("the Panel") of the Neath Port Talbot County Borough Council ("the Council") as Local Education Authority to uphold the decision to permanently exclude his son, X, from his school. He said that the head teacher's investigation into the incident had been inadequate, that Panel members had received information which was irrelevant and prejudicial to X, as well as hearing contradictory accounts of the incident. He said that defects in the head teacher's investigation, and in the Panel procedure, meant that the Panel should not have upheld the exclusion of X. He also complained about the delay in the Panel being held.

The Ombudsman did not uphold the appeal. If there were failings in the head teacher's investigation they were remedied by the provision of further information and evidence to the Panel. The Panel was entitled to attach such weight as it thought fit to conflicting evidence, and to disregard such evidence as it considered irrelevant.

The Panel did not meet within the timescales allowed in the guidance on school exclusion appeals. The Ombudsman did not agree with the Council's interpretation of the guidance on the circumstances in which this is permissible, although in the particular circumstances he was not overly critical of the short delay which had occurred.

Quick fixes & voluntary settlements

Wrexham County Borough Council – Admissions procedures and appeals
Case reference 201501998 - Report issued in September 2015
Ms B and Mr C complained about the Independent Appeal Panel ("IAP") who had heard multiple appeals on 15 & 16 June 2015 against Wrexham County Borough Council's ("the Council") (in its role as the Admission Authority for School D ("the School")) decision to refuse admission for their son, E, to attend the School for the September 2015 intake.

The IAP heard the multiple appeals as a "group" appeal in accordance with the Welsh Government's School Admission Appeals Code ("the Code") issued in December 2013. E was unsuccessful at the appeal, although other appellants were admitted, following the application of the two stage test under the Code. The complaint was that the IAP had acted unfairly when applying the "distance criteria" to the appellants in determining whether to admit additional pupils to the School, in accordance with the "prejudice" test.

Based on the evidence submitted, the Ombudsman considered that the IAP had incorrectly applied the two stage test under the Code when deciding to admit additional pupils at stage 1 of the process for multiple appeal hearings which proceed as a group appeal.

Following discussions with the Council, it agreed to take the following actions to resolve the matter as a voluntary settlement:

a) E was offered a place at School D for the September 2015 intake, which has been accepted

b) the IAP members would undergo retraining. This will be included within the annual training sessions provided to IAP members

c) a letter would be sent to the Welsh Government to seek clarification on the School Admission Appeals Code in relation to multiple appeals. A copy of this letter would be provided to the Ombudsman within three months.

Environment & Environmental Health

Quick fixes and Voluntary settlements

Cardiff Council - Refuse collection, recycling and waste disposal
Case reference 201501781 – Report issued in July 2015
Mr A complained about frequent issues with his refuse collections. Although he contacted Cardiff Council ("the Council") each time his refuse was not collected, and the Council then took steps to collect the outstanding waste, he was unhappy that the issue kept reoccurring.

The Council stated that it has now implemented several actions which it hoped would prevent the issue reoccurring again in the future. It also agreed to:

a) make a one-off payment of £25 to Mr A in recognition of the inconvenience caused, and

b) if the issue did occur again, to formally consider it through its Corporate Complaints Procedure, taking into account all the previous instances.

Flintshire County Council
Case reference 201501721 – Report issued in July 2015
Mr D complained that Flintshire County Council ("the Council") failed to answer his letters and told him it wanted to purchase his home but then changed its mind. Mr D further complained that his house was subject to severe pollution but the Council had failed to take any action to resolve it After considering documents, the Ombudsman contacted the Council and asked that it meet with Mr D to discuss his concerns and attempt to resolve them. The Council agreed to contact Mr D to arrange a meeting.

The Ombudsman is satisfied that the action which the Council has said it would take was reasonable and would resolve this complaint. Accordingly, he considered the matter to be settled. The Ombudsman told Mr D that if he remained dissatisfied with the explanations provided it would be open to him to raise a formal complaint with the Council for investigation in line with its complaints procedure.

Finance and Taxation

Quick fixes and Voluntary settlements

Gwynedd Council – Finance and taxation
Case reference 201501820 - Report issued in August 2015
Mrs A complained that Gwynedd Council ("the Council") failed to reply to her complaint about the interest charges on the deferred care home fees relating to her late mother. Whilst initially saying it would respond to her complaint, it subsequently said that it could not on the basis of its interpretation of the Grant of Probate.

The Ombudsman's office contacted the Council and it agreed to:

a) apologise for misinterpreting Mrs A's legal status

b) apologise for the unreasonable and unnecessary delay caused by this

c) arrange a meeting with relevant officers to discuss the complaint

d) provide a response to the complaint.

Carmarthenshire County Council – Finance and taxation
Case reference 201502000 - Report issued in September 2015
Ms X said that she owed monies to Carmarthenshire County Council ("the Council"). She paid the money into a different Council account which the Council were aware of. Ms X said bailiffs were instructed to recover this amount. Ms X said she did not owe the Council money and she unfairly incurred bailiff costs.

The Council said that Ms X made no payment towards the bailiffs cost, which were not sought, as she had entered into a repayment plan. The Ombudsman found that that as Ms X had entered into a repayment plan, and there was no payment towards the bailiffs cost, the investigation was discontinued.

Housing

Quick fixes and Voluntary settlements

Valleys to Coast - Repairs and maintenance (including dampness/improvements and alterations e.g. central heating. double glazing)
Case Number: 201404593 Report issued in July 2015
Mrs A complained that, given the extent of the work required to her home, her landlord, Valleys to Coast ("V2C"), should have provided her with temporary accommodation while the work was being carried out. Due to her concerns about the extent of the work, Mrs A said that she felt she had no option but to move to another property. V2C met with Mrs A at the outset of the investigation. It identified that Mrs A felt let down and unsupported when she decided to move and offered to formally apologise for not meeting her expectations and offered a payment of £250 as a gesture of goodwill. The investigation continued at this stage to consider the complaint further before determining the reasonableness of the offer.

On the basis of the evidence reviewed, the Ombudsman was unable to conclude that the extent and nature of the work required to the property should have led to Mrs A being decanted in line with V2C's decant policy. However, the investigation identified some shortcomings in record keeping.

The complaint was settled when V2C agreed to the following:

a) to implement the proposal it initially put forward

b) to issue a reminder to all staff about the importance of record keeping.

Charter Housing Association (Derwen Cymru) - Other
Case Number: 201500480 – Report issued in July 2015
Mr T complained that Charter Housing Association ("The Association") failed to advise him about an increase in his rent in line with its Tenancy Agreement. It also failed to advise him that the road outside his home was un-adopted by the Council, which caused a substantial increase in the Service Charge element of his rent from £1.95 to £8.48 from 7 April 2014.

The investigation found that the increase in rent had been introduced without proper consultation. The Ombudsman made the following recommendations which the Group has agreed to:

a) make a payment of £250 to Mr T in recognition of the time and trouble he took to make a complaint

b) reimburse Mr T and each of his fellow tenants paying rent in the housing complex (or the Housing Benefit Department in the case of those in receipt of it) the sum of £111.18 in recognition of the increase that was incorrectly introduced between 7 April 2014 and 1 August 2014. The payments will be will be made within two months of the date of the settlement letter.

Cardiff Council - Repairs and maintenance (inc. dampness/improvements and alterations e.g. central heating. double glazing)
Case Number: 201500783 - Report issued in July 2015
Following a previous complaint to the Ombudsman, Mr K raised concerns that works undertaken by the Council to resolve a problem with his gutters had not been completed satisfactorily. The Council arranged for a roofer from its Community Maintenance Services Department to attend Mr K's property to enlarge the drainage holes to the guttering. The roofer was scheduled to attend the property on 11 August 2015.

Denbighshire County Council - Neighbour disputes and anti-social behaviour
Case reference 201409755 - Report issued in August 2015
Mrs X complained about the manner in which Denbighshire County Council ("the Council") had dealt with issues between two of its neighbouring tenants.

Following contact from the Ombudsman's office, the Council agreed to take action to improve the issues of concern between the tenants.

Wrexham County Borough Council - Repairs and maintenance (inc dampness/ improvements and alterations e.g. central heating. double glazing)
Case reference 201502803 – report issued in August 2015
Mrs B complained that Wrexham County Borough ("the Council") had failed to deal adequately with her complaint that a concrete cladding slab was unsafe at her home, which later fell off. She also complained that the Council had not attended her home to assess the vibration being caused to the property since new communal doors had been fitted.

The investigation found that although the Council had visited the address, there had been little contact with the complainant regarding the issues she complained of.

Following contact from the Ombudsman's office, the Council agreed to:

a) visit Mrs H at home, within the next 20 working days (of the date of this summary), where an assessment of the building and her concerns regarding the missing slab and door vibration can be made, in her presence

b) send a letter to Mrs H within 10 working days of the visit, outlining any findings from the assessment and what action the Council intends to take to address any issues identified during the visit. It should also provide a proposed timeline for any actions identified.

Cardiff Council - Repairs and maintenance (inc. dampness/improvements and alterations e.g. central heating. double glazing)
Case reference 201501397 – report issued in August 2015
Mr A complained that Cardiff Council ("the Council") unnecessarily delayed repairing the ceiling in one of the bedrooms at his property. Mr A said that he waited more than 18 months for the repairs to be completed and was concerned that a number of appointments made were cancelled by the Council.

On receipt of the complaint, the Ombudsman's office contacted the Council and highlighted a period when the repairs were delayed by problems relating to the Council's contractors. The Council agreed to pay Mr A £70 in respect of inconvenience caused by the delay in the completion of the repairs during this period.

Powys County Council - Repairs and maintenance (inc dampness/improvements and alterations e.g. central heating, double glazing)
Case reference 201502180 – report issued in August 2015
Mr D complained that Powys County Council ("the Council") workmen had sprayed the front of his property with muddy water when cleaning the highway outside. When returning to clean this, he alleged that damage was caused to his property. The Council denied liability through its insurers but later its complaints investigation (7 months after Mr D first complained) agreed that Mr D's property had been sprayed with dirty water in the first instance, albeit denied that actual damage was caused when it later undertook its cleaning. The Council also stated that steps would be taken to prevent such happening when undertaking future road cleaning.

The Ombudsman did not investigate the complaint regarding alleged damage, as he was not in a position to definitively establish liability/ causation. However, the Ombudsman found that there had been communication failures and shortcomings in the way in which the Council had first handled Mr D's complaint. Having later acknowledged that Mr D's house had been wrongly sprayed with muddy water (and that it would take future remedial steps to avoid recurrence), it had not apologised to him.

The Ombudsman considered the following to be a reasonable resolution and the Council agreed to the following actions within 20 working days:

a) provide Mr D with a written apology

b) offer Mr D redress of £75.

Cartrefi Cymunedol Gwynedd - Repairs and maintenance (inc dampness/improvements and alterations e.g. central heating. double glazing)
Case reference 201502552 – report issued in August 2015
Mr R was a tenant of a flat owned by Cartrefi Cymunedol Gwynedd ("CCG"). He complained in November 2014 that he was unable to open his bathroom window and so there was a condensation problem. An officer from CCG inspected the property in January 2015, giving advice about

mitigating condensation. Mr R began withholding his rent. Ventilation was installed to the bathroom in May. Mr R complained that CCG ought to have dealt with his problem sooner, reduced his rent in the interim, and that it should compensate him. He was now in arrears.

On reviewing the documentation, the Ombudsman established that CCG knew that the flat (and block) was prone to condensation problems. He considered that an inspection of Mr R's flat, and the installation of ventilation to deal with the issue, should therefore have been undertaken sooner than it did. However, the Ombudsman did not consider a detailed investigation was needed.

CCG agreed to his recommendation to settle the complaint within 20 working days on the following basis:

a) provide Mr R with a written apology

b) offer Mr R redress of £750.

Newport City Homes - Housing – Other
Case reference: 201501668 – Report issued in September 2015
Mr A complained that when Newport City Homes ("the Housing Association") erected a new boundary fence on its land to the rear of his privately owned property, it did not incorporate a gate and blocked his existing access to a car park behind.

On receipt of Mr A's complaint, the Ombudsman contacted the Housing Association and suggested that there was action it might take to resolve the matter quickly. The Housing Association agreed to undertake the following in settlement of the complaint:

a) respond to Mr A in accordance with stage 2 of its Complaints Procedure;

b) apologise for its poor handling of Mr A's complaint

c) offer Mr A £150 in recognition of his time and trouble

d) clarify the legal position with regard to Mr A's right of access to the car park, and

e) clarify the terms of an offer to sell Mr A the meter strip of land in its ownership that runs from his boundary up to the new fence.

Planning and Building Control

Upheld

Carmarthenshire County Council - Other planning matters
Case reference 201303358 Report issued in July 2015
Mr and Mrs A complained that Carmarthenshire County Council ("the Council"), when granting planning consent, had failed to apply conditions to enable it to take enforcement action against the developer to ensure he built their property to national sustainable homes standards. Mr and Mrs A were also dissatisfied with the Council's handling of enforcement issues that they raised.
The Ombudsman's investigation found that whilst the Council had been maladministrative in failing to apply conditions, nevertheless, Mr and Mrs A as purchasers should have satisfied themselves, via their legal representative, that contractually the property met their requirements. The Ombudsman made no finding against the Council in respect of this aspect of Mr and Mrs A's complaint.

In the absence of any evidence to the contrary, Mr and Mrs A's concerns that the Council had breached their confidentiality and passed details of their complaint to the developer were not upheld.

The investigation did identify shortcomings in communication within the Council which extended to record keeping. There was also a failure by the Council to recognise when its discretionary enforcement powers had been triggered. The Ombudsman upheld this aspect of Mr and Mrs A's complaint.

The Ombudsman recommended the following:

a) the Council should apologise to Mr and Mrs A for the failings identified in the report

b) in recognition of the inconvenience and distress caused to Mr and Mrs A which extended to the Council's communication processes and its handling of the enforcement matters that Mr and Mrs A raised, the Council should make a payment to them of £350

c) finally, the Council should consider if it was possible and expedient at this date to take any enforcement action in relation to the footways and notify Mr and Mrs A in writing of its decision.

Denbighshire County Council – Building control
Case reference 201400990 - Report issued in September 2015
Mrs E complained about the manner in which Denbighshire County Council ("the Council") considered a planning application for a proposed dwelling on the site to the rear of Mrs E's property. Mrs E said that there was a failure to properly interpret and apply relevant legislation, policy and guidance. She also complained that the Council did not give good reason for deciding the application contrary to policy.

The investigation found that the Council had failed to complete the validation process properly, resulting in the committee not being aware of the potential scale of the property preventing proper consideration of some of its policies. It also found that members had failed to properly interpret one of the Council's policies, resulting in the classification of the application as infill development.

The Ombudsman recommended that:

a) the Council ensures that its validation process is updated to ensure that it takes into account the statutory requirements set out in article 3 of the Town and Country Planning (Development Management Procedure) (Wales) Order 2012

b) the Council shares this report with the planning committee and arranges additional training for the Planning Committee which encompasses the failings identified in this report
c) the Council ensures that it accurately records reasons given for decisions taken which are contrary to Officer advice

d) based upon the findings in this report, the Council considers whether it is appropriate to revoke the permission it has granted

e) that if following on from d), the Council ultimately determined not to revoke, then within one month of the completion of the development, the Council would instruct the District Valuer to assess the impact of the development on Mrs E's properties and pay her an amount which equates to the difference in value before and after the development.

The Council agreed to implement these recommendations.

Not Upheld

Carmarthenshire County Council - Other planning matters
Case reference 201401903 – Report issued in July 2015
Mr B complained that Carmarthenshire County Council ("the Council") failed to take appropriate enforcement action to require the developer of the self-build housing estate where he lives to comply with planning conditions regarding:

• the construction and completion of the estate's pavements and access road(s)
• the surface water drainage and disposal measures
• the proposed landscaping scheme.

Mr B also complained that the Council:
• approved the second phase of the development without requiring the developer to fully comply with planning conditions that applied to the first phase

• failed to advise potential purchasers of the self-build plots that the proposed design of the access road precluded its adoption

• provided information to residents concerning the adoption/non-adoption of the access road that was confusing and contradictory.

Finally, Mr B complained that since receiving his initial complaint in May 2013, the Council had:

- only partially enforced breaches of planning control

- failed to satisfactorily clarify how the design of the access road was approved when the Highways Department advised that the application should be declined on road safety grounds

- failed to answer "pertinent questions."

The Ombudsman did not uphold Mr B's complaints. Drawing on advice from his Professional Planning Adviser, the Ombudsman determined that the Council had acted reasonably and in accordance both with planning guidance issued by the Welsh Government and with legal procedures governing the adoption / non-adoption of roads. However, the Ombudsman requested that the Council provides Mr B with a consolidated and updated account of the current position with respect to ongoing enforcement action.

Quick fixes & voluntary settlements

Cardiff Council - Tree management/TPOs/High hedges
Case reference 201501716 – Report issued in July 2015
Mrs W complained that she had raised a complaint with Cardiff Council ("the Council") regarding its tenant's tree overhanging her garden and causing damage. Mrs W says that she had received a response to that complaint from the Council but she was not happy as no one had visited her property to inspect the damage it had caused her.

On receipt of this complaint, the Ombudsman contacted the Council which agreed to arrange a visit to inspect the tree and the damage it had caused. Therefore, the Ombudsman believed that the action which it had said it would take was reasonable and would resolve Mrs W's complaint.

Accordingly, the Ombudsman considered the matter to be settled. However, Mrs W was advised that if the action promised by the Council did not materialise or was unsatisfactory she could come back to the Ombudsman's office.

Cardiff Council – Handling of planning application (failure to notify those affected)
Case reference 201408741 - Report issued in August 2015
Mrs W raised a complaint regarding the delay by Cardiff Council ("the Council") in responding to her complaint that was originally made in November 2014. Mrs W received a response to her complaint in March 2015.

The Ombudsman's office contacted the Council to discuss the complaint and noted that the complaint was not considered in a timely manner due to a breakdown of communication, which denied Mrs W the opportunity to approach the Ombudsman at an earlier stage.

Following this discussion the Council agreed to make a payment to Mrs W in the sum of £150 to reflect the time spent in pursuing her complaint and inconvenience caused.

Ceredigion County Council – Other planning matters
Case reference 201500894 - Report issued in August 2015

Mr A complained that highways officers had given contradictory advice about the feasibility of a proposal to erect a fence around the curtilage of his property. Mr A said that he purchased materials in 2013 on the basis of Ceredigion County Council's ("the Council") advice that he could erect a fence which it later went back on. The Council did not accept that its advice was contradictory and said that its records showed Mr A had asked for advice on two different proposals. It stood by the advice but accepted that officers might not have fully explained the implications of erecting a fence in the given the location which could have an effect on the public's rights of way.

The Council agreed to:

a) write to Mr A to fully explain the position concerning the erection of a fence outside his property

b) apologise to Mr A for the confusion which arose in respect of this when dealing with his complaint

c) pay Mr A £150 as a gesture of goodwill for the cost of the fencing materials he purchased.

Roads and Transport

Quick fixes & voluntary settlements

Wrexham County Borough Council - Road maintenance/road building
Case reference 201501263 - Report issued in July 2015
The Ombudsman received a complaint from Mr O in March 2014, saying that he was dissatisfied with Wrexham County Borough Council's ("the Council") failure to assess the nuisance caused by traffic traversing over a traffic calming measure. Following assessment of the complaint, the Ombudsman asked the Council to carry out an inspection of the site to determine whether any deterioration had occurred over the years. Mr O again complained to the Ombudsman in September 2014 saying that the Council had not carried out a site inspection. Following discussions with the Council and Mr O it was agreed that noise monitoring equipment would be installed to assess whether there was a statutory nuisance.

Mr O then contacted the Ombudsman in May 2015 complaining that the Council had failed to contact him to arrange for the installation of the noise monitoring equipment. The Council has apologised for its failure to take the agreed action and will be installing noise monitoring equipment at the earliest opportunity. The Council said that, if it is considered appropriate, it will propose to carry out the nonstandard procedure of installing vibration monitoring equipment on this occasion. The Council has offered to undertake this exercise, as a gesture of goodwill and in recognition of its failings not to act more speedily in response to the complaint.

Welsh Government – road maintenance/road building
Case reference 201502487 - Report issued in August 2015
Mr P complained about the conduct of the Welsh Government in the governance around a proposal for the removal of a section of Ystrad Mynach School sports field and the construction of a road to enable access to a Park and Ride car park adjacent to the train station.

Mr P said he had not received any correspondence from the Welsh Government regarding his complaint. The Ombudsman therefore contacted the Welsh Government to discuss Mr P's concerns and was provided with a copy of a response it said it e-mailed to Mr P on 9 March 2015. However, upon reviewing the letter, the Ombudsman did not consider the contents to be an appropriate response to the number of concerns Mr P had raised. The Ombudsman therefore asked the Welsh Government to reconsider the details of the letter and provide a more detailed and substantial response which it agreed to do.

Gwynedd Council - Roads and Transport - Other
Case reference: 201501780 – Report issued in September 2015
Mrs J complained that Gwynedd Council ("the Council") failed to act with urgency to deal with issues (housing adjustments) that could make her brother's life more bearable and that the Council failed to communicate effectively with her.

The Council provided information which stated that all work had now been completed or had at least started. It confirmed that the application for the bathroom ramp was made in March and was completed soon after. It also confirmed that a ramp for the front door was discussed, however, this was not possible and a temporary ramp was put in place whilst an application was submitted to widen the front door. The Ombudsman informed that this work had already started.

Finally, with regards to the parking outside of the home, an application was received by the Council and this was approved. The Transportation and Street Care Service were putting the necessary procedures in place to facilitate the new parking provisions and the Ombudsman was informed by the Council that the parking markings are now in place.

Social Services - Adult

Upheld

CSSIW, Wrexham Council & Betsi Cadwaladr Health Board – Services for older people
Case references 201204596, 201204839 & 201205177 – report issued in August 2015
Mr W complained about the care his late father, Mr AW, had received at the Nant y Gaer Hall care home. He also complained that the Care and Social Services Inspectorate Wales (CCSIW), Wrexham Council ("the Council") and Betsi Cadwaladr Health Board ("the Health Board") had not properly addressed the failings in his father's care at the home. He also complained that these bodies' investigations had been flawed; this included a protection of vulnerable adults investigation. Mr W had complained to the bodies concerned and also to the Nursing and Midwifery Council and the Welsh Government. In view of the previous investigations and admission of failings by the bodies, Mr W was advised that the Ombudsman's investigation would take the form of a review of the care at the home and an examination of what the regulatory bodies had done, to see if their action plans had been comprehensive.

The investigation involved the Ombudsman's professional advisers on social care, medicine and nursing. The investigation did not find evidence that the clinical care of Mr AW at the home had been below standard and so this element of the complaint was not upheld. It was decided that the complaint against the Health Board should not be upheld as it had already taken appropriate remedial action.

It was noted that CSSIW and the Council had already taken significant steps to address past failings and so the complaint against them was only partly upheld. The bodies accepted some further recommendations aimed at improving their training and procedures.

Not Upheld

Nant Y Gaer Hall Nursing Home - Services for older people
Case reference 201301782 - Report issued in August 2015
Mr W complained that the care home had failed to care for his father, Mr AW. Mr AW was an older person with dementia, diabetes and other health concerns. Mr W believed that an ambulance had not been called promptly and that his father had developed pressure sores that had not been noticed by the staff. He was also concerned that a hoist had not been used to lift his father when he became weak. He was concerned about record keeping at the home and that people had not been held properly accountable for failings.

Mr W had previously complained to the home and the Nursing and Midwifery Council about these matters. He had also complained about to CSSIW, the Betsi Cadwaladr University Health Board, Wrexham Council and the Welsh Government.

The records of Mr W's care were examined by the Ombudsman's professional advisers on nursing and medical care. The medical adviser noted that Mr AW's health had been in decline for some time and that he had become weaker in the last four days. He concluded that his decline was in

keeping with his health profile and that there were no identifiable failings in care. The nursing adviser could identify no failings in nursing care from the records available.
Having examined the action plans produced by the regulatory bodies, it was found that concerns about nutrition and record keeping had already been addressed with the home and there was no need to make further recommendations.
The complaint against the nursing home was therefore not upheld.

Quick fixes & voluntary settlements

Ceredigion County Council - Adult Social Services
Case reference: 201502390 – Report issued in September 2015
Mr D complained that Ceredigion County Council ("the Council") failed to comply with a number of action points agreed by way of resolution to an earlier concern about care services provided to him (case ref 201403844). Mr D has cancelled his care services as a result of his complaints.

Mr D said that the Council failed to prepare a new risk assessment and a code of behaviour as agreed. Mr D said that he asked the Council to prepare these in case he chose to receive services at some time in the future. He expressed concern that the Council had refused to do this and confirmed that these processes, if he chose to receive care services, would be completed by a domiciliary care agency rather than the Council itself.

In addition Mr D said that the Council had failed to respond to a complaint he made about the way in which he was described in correspondence by a Council employee.

The Council confirmed that it changed its domiciliary care processes in October 2014 and that all care and assessments are now provided by a commissioned domiciliary care agency.

The Council agreed a number of actions:

a) apologise to Mr D for failing to advise that him that the processes commissioning domiciliary care services had changed previously

b) apologise for failing to respond to his complaint made in April 2015 and to make a payment of £25 to Mr D in recognition of the time and trouble taken to pursue this matter.

Social Services - Children

Quick fixes & voluntary settlements

Bridgend County Borough Council - Children in care/taken into care/'at risk' register/ child abuse/custody of children
Case reference 201502473 – report issued in August 2015
Mr J complained that Bridgend County Borough Council ("the Council") had failed to look after his best interest and it had not followed its own policies and procedures in ensuring savings were made for a child in care.

The Ombudsman concluded that the Council's letter dated 25 June 2015 did not provide a clear explanation of the recorded savings. Following discussions the Council agreed that it would write to Mr J and provide him with a further explanation in relation to:

a) how a £200 interest payment was devised

b) the outgoings of the recorded savings and any incurring costs

c) the expectation that foster carers should put aside monies each week for a child in care.

City and County of Swansea Council - Other
Case reference 201502826 – Report issued in August 2015
Mrs T complained that she made a number of specific complaints to City and County of Swansea Council ("the Council") about a social services matter. She said that the Council responded by stating that as court proceedings had taken place, it was not appropriate to respond.

The Ombudsman considered that the Council was right about some but not all of the matters that Mrs T had raised. He asked the Council to reconsider Mrs T's complaints and the items that were not addressed due to court proceedings.

Powys Council – Children's Social Services – Adoption procedures
Case reference: 201502692 – Report issued in September 2015
Mr and Mrs D complained that Powys Council ("the Council") failed to adhere to its own processes whilst they were trying to become foster parents. Mr and Mrs D said they felt 'let down' by the Council as this was their 'ambition' and a 'future career' for themselves and their family.

Having considered the information provided by Mr and Mrs D and the Council the Ombudsman was satisfied that the Council had investigated and addressed the issues Mr and Mrs D had raised. Whilst he appreciated that Mr and Mrs D may not accept that their complaint had been fully resolved to their satisfaction, he was not persuaded that further investigation would have achieved anything more than the action already taken by the Council.

Upon assessing the complaint it became clear to the Ombudsman that Mr and Mrs D had not received a response to their letter dated 29 January 2015. The Council did not have an explanation for this and apologised for this oversight. The Ombudsman informed the Council that a response needed to be issued to Mr and Mrs D by Thursday, 17 September 2015. It agreed to do this along with an apology for not responding sooner.

Various Other

Quick fixes & voluntary settlements

Cartrefi Cymunedol Gwynedd - Other miscellaneous
Case reference 201501444 – Report issued in July 2015
Mrs S complained that Cartrefi Cymunedol Gwynedd ("the Housing Association") had failed to deal adequately and in a timely fashion with her complaints about damage caused by contractors carrying out work at her home. This included damage to linoleum flooring, for which the Association had offered £150 as a goodwill gesture, and the loss of food due to her freezer being accidentally turned off. She was advised to claim against the sub contractors regarding the second matter.

It was discovered that there were delays in dealing with her complaints and that the issue regarding the loss of food had not been dealt with satisfactorily. The following recommendations were made and were agreed by the Association:

a) write a letter of apology to the complainant indicating that in future it will oversee any claims made against sub contractors working on its behalf and ensure that there is an agreed service level agreement and provide details of the timescale in which this procedure will be implemented
b) offer the £150 that was originally offered in a letter dated 27 November 2014 as a goodwill gesture for the damage to the linoleum flooring
c) offer £250 as a redress payment for time and trouble taken by the complainant in pursuing this complaint.

The letter and payments were to be completed within 20 working day of the date of a settlement letter sent by this office.

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 Matt.Aplin@ombudsman-wales.org.uk or Lucy.Geen@ombudsman-wales.org.uk, or sent to the following address:

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

BRIDGEND COUNTY BOROUGH COUNCIL

REPORT TO STANDARDS COMMITTEE

26 JANUARY 2016

REPORT OF THE MONITORING OFFICER

STANDARDS CONFERENCE WALES 2015

1. Purpose of Report

1.1 The purpose of this report is to provide the Committee with an update from the Standards Conference Wales 2015.

2. Connection to Corporate Improvement Plan / Other Corporate Priority

2.1 Standards are an implicit requirement in the successful implementation of the Corporate Themes.

3. Background

3.1 The Standards Conference Wales 2015 took place on 19 October 2015, hosted by Cardiff City Council.

4. Current Situation / Proposal

4.1 The theme for the conference was "Standards and Ethics in a Changing World" to reflect the challenges being faced by the Welsh local government sector.

4.2 There were a total of 117 attendees at the conference from 27 organisations from across the Welsh public sector, including representatives from every principal council in Wales, many Community Councils, the National Parks authorities and Fire and Rescue Services.

4.3 The Conference provided an opportunity to hear directly form senior officials involved in the adjudication of the Code of Conduct. Mr Nick Bennett, Public Services Ombudsman for Wales was also in attendance.

4.4 A copy of the Standards Conference Report is attached as **Appendix 1** for information. The slides from the conference are also available at: https://www.cardiff.gov.uk/ENG/Visiting/SCW2015/Presentations/Pages/default.aspx.

5. Effect upon Policy Framework& Procedure Rules

5.1 There is no effect upon the Policy Framework and Procedure Rules.

6. Equality Impact Assessment

6.1 None.

7. Financial Implications

7.1 None.

8. Recommendation

8.1 It is recommended that the Committee note the report.

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Background documents
None

Standards Conference Wales 2015 – Standards and Ethics in a Changing World

The theme for this year's conference was "Standards and Ethics in a Changing World" to reflect the challenges being faced by the Welsh local government sector. The conference aimed at reinforcing the importance of promoting and maintaining high standards and conduct and the connection between good conduct, good governance and excellent service delivery. The conference also provided an excellent opportunity to share ideas, best practice and learning.

There were a total of 117 attendees at the conference from 27 organisations from across the Welsh public sector, including representatives from every principal council in Wales, many community councils, the national parks authorities and fire and rescue services.

The slides from the conference are available here:
https://www.cardiff.gov.uk/ENG/Visiting/SCW2015/Presentations/Pages/default.aspx

Summary of the conference presentations

The opening session started with a keynote speech from **Nick Bennett**, the Public Service Ombudsman for Wales who reflected on whether the Nolan Principles are fit for purpose in the current climate and for the next 20 years. Key points from this presentation are summarised below:

- In the current context of an ageing population, cuts in public spending, NHS/Social Services integration, potential local government reorganisation and the likely move towards further reductions in the size and level of state provision - the Nolan principles are still fit for purpose but possibly no longer sufficient.

- There needs to be leadership - effective and distributed – in addition to the principles and formal complaints machinery. Many complaints to the Public Service Ombudsman are vexatious (such as councillors 'tutting and huffing'), due to a lack of leadership.

- There is a need to "set a watchman" first before coming to the Ombudsman as their resources are limited. Everyone from frontline staff to those responsible for governance should be the watchmen.

- Nick welcomed the new Public Service Ombudsman (Wales) Bill because it allows the Ombudsman to move from being reactive to working on their own initiative. The Bill (if and when enacted) will enable them to consider complaints about private hospitals (if services are commissioned by private citizens) and to receive complaints made orally.

Three further speakers also shared their thoughts on the Nolan Principles and their current utility.

Lyn Cadwallader - Chief Executive, One Voice Wales

- Lyn also outlined the importance of effective leadership at all levels of government.

- He welcomed the requirements of the Well-being and Future Generations Act to produce annual reports and a performance management approach for Community and Town Councils (C&TCs).

- The Welsh Government needs to define the purpose of C&TCs so that they can move forward more confidently. It is clear that C&TCs need a cultural shift including new capacities and skills so that they are able to become delivery bodies. C&TCs also need to have a clear electoral mandate and manage effective consultation as public perception of their work is low.

- While the number of complaints emanating from C&TCs has gone down in recent years, more councils need to take up training on ethics and standards.

Peter Davies, President of the Adjudication Panel Wales

- Equality and respect remain the most significant issues for standards and ethics. This means that there is a continual need for training for councillors and refresher courses.

- Internal systems need be supported by external monitoring, but are members of standards committees too close to be objective and independent?

Jan Williams, Independent Police Complaints Commissioner for Wales

- Jan also emphasised the importance of leadership. It's all about setting appropriate standards, culture, and doing the right thing every day which requires ethical behaviour. You don't simply need policies, procedures or codes but training is vital and avoiding tribalism when things go wrong.

Workshops

Five workshops were run on two occasions in the conference.

1. **Social Media – Staying out of Trouble - Patrick Arran, Head of Legal, Democratic Services & Procurement, City and County of Swansea Council and Daniel Hurford, WLGA.**

This workshop was structured into two parts. The first focused upon how different types of social media (e.g. Facebook, Twitter and blogging) can be used to stay in touch with the public and strategies for using it effectively. The second part concentrated on how to stay out of trouble by providing information on legal issues, and recent case law as the law of defamation can apply to social media issues.

Email and social media have been seen to change councillors' behaviour and has resulted in them posting items on social media that they would not usually have said and putting things in email that they would not have put in a 'formal' communication such as a letter.

Social media has the potential to have a significant positive effect on councillors and council life but care needs to be taken due to immediacy (once you have posted something, you can't withdraw it), issues of tone/voice, and the fluid boundaries between a person's role as a councillor and their private life.

Social media provides a two-way opportunity for the council and councillors to gain information and intelligence about the people they serve as well as putting information out there, but it must be used responsibly and the risks must be managed.

2. **Whistleblowing - Sioned Wyn Davies, Legal Services Manager & Deputy Monitoring Officer, Wrexham County Borough Council with Kumi Ariyadasa, Solicitor at City of Cardiff Council.**

This workshop reviewed best practice and guidance, the role of standards and ethics committees in reviewing cases, and communication approaches. It considered the role of the committee in meeting its statutory requirements and its wider role/interest in ethics and the culture of the organisation to promote standards.

There was much discussion in the workshop about the role and remit of standards and ethics committees, and whether those that were named 'standards committees' had a more restricted remit than those whose role explicitly includes ethics as well; and to what extent committees should be proactive rather than simply reactive. It was noted that some councils have added matters such as oversight of whistleblowing arrangements to the statutory functions of their standards committees, as permitted by law. The rationale for this approach being that whistleblowing is a report made in the public interest, which may raise ethical issues and impact on public perception. Other councils have adopted different arrangements, regarding whistleblowing as purely an employment matter, and others report to Scrutiny or Audit Committees.

It was acknowledged that effective whistleblowing arrangements provide protection for Council workers as well as for the organisation. However, some organisations may be struggling with getting to grips with their whistleblowing procedures; and the culture and attitudes within those organisations need to be brought into line with the Nolan principles.

The importance of leadership, culture, and staff ownership, as well as clear procedures and training were emphasised and it was generally agreed that an alternative to line management both inside and outside the organisation should be available. Some participants suggested that whistleblowing should be handled outside of local authorities to promote objectivity, and that this should be pursued nationally, involving the Public Service Ombudsman.

3. Community Councils – Governance and Standards - Iwan Evans, Monitoring Officer, Gwynedd Council and Lyn Cadwallader, Chief Executive, One Voice Wales.

This workshop looked at the proposed new Welsh Government tests of competency; democracy, capability, capacity and governance. The practical implications of those tests were considered. This reflected on the significant variation in terms of population and resource and staff capacity which existed across the sector in Wales. There was a perception that the achievement of these thresholds would present different challenges to different authorities.

Developing from that discussion the role of partnerships and joint working as a vehicle for developing capacity was discussed and the discussion highlighted examples of joint arrangements which were already effective or being developed. The discussion also reflected the fact that where joint arrangements were being developed issues of governance and accountability were being encountered and responses and solutions being found.

The discussions also drew us to the current financial challenges and the role Community Councils might have in participating or providing services in lieu of or with the County Councils. There were concerns about the speed of the changes taking place and the ability of Community Councils to respond particularly if this involved changes to the precept. There was a clear feeling that dialogue was needed around expectations and capacity.

The groups also considered issues around governance and the Code of Conduct. A discussion theme which came out was around the experience of some Councils around difficult members and the impact they could have on the transaction of business. Local resolution processes at a Community Council level could be considered but there needed to be an acknowledgment that they were mostly small organisations trying to deal with these issues.

4. Local Complaints Resolution – Practicalities - Mel Jehu MBE, Chair of Rhondda Cynon Taf County Borough Council Standards and Ethics Committee and Paul Lucas, Director of Legal and Democratic Services, Rhondda Cynon Taf County Borough Council.

The workshop reviewed the experience of RCT Standards Committee in implementing a Local Resolution Procedure for low level Member on Member complaints.

It was noted that the introduction of the Protocol had led to an improvement in Member's behaviour: No new cases had been received since April 2013. The importance of firm action from Standards Committee Members in dealing with hearings and complaints under the Local Protocol was stressed. A key outcome was a better understanding of what could be considered a legitimate complaint and where to draw the threshold level of the cut and thrust of political debate.

There was much discussion in the workshop about the possible extension of a local resolution procedure to town and community councils.

A key issue was the lack of sanction (other than censure) to deal with persistent low level behaviour from Members who refused to engage with the local resolution process. The inherent powers of a Council to regulate behaviour as set out in the 2001 case of R v Broadland District Council ex parte. Lansley was also discussed in this context.

Finally, it was noted that the Local Government (Wales) Bill was likely to expand the role of Standards Committees to regulate the performance of Members i.e. attendance at meetings and training.

5. Are the Nolan Principles fit for purpose in the current climate and for the next 20 years? - Nick Bennett , Public Services Ombudsman and Delyth Jones, Monitoring Officer, Conwy County Borough Council.

This workshop continued the discussion from the morning session.

Common themes at the conference

There are multiple leaders who act on ethics in an organisation. These include the Leader of the council and other party group leaders, party whips, the chief executive, monitoring officer and the standards committee. They *all* have a role to play in trying to improve the ethical culture of councils. The Code of Conduct is an important backstop, but it is important for the leaders to work informally by setting an example for others to follow and working closely with individuals (in party groups especially).

When unethical behaviour does occur, conference attendees raised concerns about the type of sanctions available (their severity), how these were applied and the 'power' of censure as a sanction. Linked to this point, councils were keen to hear the different ways in which councils have successfully dealt with 'rogue' individuals.

There was also discussion on the role of Standard and Ethics Committees after the Calver judgement which has raised the threshold of what is regarded as being unethical conduct of councillors. A number of questions were posed:

- Should committees be more assertive in drawing their own line of what is not acceptable behaviour?
- Should committees be more proactive in 'looking for work' in trying to improve the ethical culture of organisations?
- At what point do Standards and Ethics Committees risk losing our independence?

Ultimately, prevention is better than cure and training is therefore crucial in disseminating the various messages of ethical behaviour. There was discussion on whether training could be made available in different formats to suit the learning styles of councillors and whether training could be made mandatory. What other methods, beyond training, are available to promote good conduct between councillors?

The conference featured interesting debates on Community and Town Councils. Given the possibility that C&TCs will be given more responsibilities, there was a concern that the support they receive on ethical issues varies across principal councils. More thought needs to be given to ensuring that C&TCs are kept fully in the loop and properly supported. The conference heard that clerks seemed to have little recourse when treated inappropriately by members, especially since the Calver case which suggested that politicians are entitled to be robust in a political context.

Three-quarters of complaints to the Public Service Ombudsman are closed after initial consideration. It is important, therefore, that councillors understand this and that the exercise of examining complaints locally and by the Ombudsman is costly and using scarce resources.

The behaviour of the large majority of councillors is high and instances of corruption in Welsh local government are rare. More should be done to share this fact proactively, although there are concerns that the media may not be interested in a 'good news' story such as this.

Good practice examples

It is important to have regular events, such as this conference, to share 'good practice' between local councils. Examples included:

- Cardiff Council requires all councillors to annually sign the 'Cardiff Undertaking' which reinforces the Members' Code of Conduct and forms part of the ethical code binding upon all Cardiff County Councillors.
- Chairs of Standards and Ethics Committees in North Wales meet on a regular basis to share knowledge, but this doesn't happen in South Wales.
- Members of Ceredigion's Standards Committee have visited all Community Councils in their area.
- Councils have different ways of conducting local resolutions. In RCT, the whole council is involved rather than just three Independent members in Cardiff. Which process is working better and why?
- There is variety in the extent of training conducted for members of Committees. RCT use structured role-play in their training of members and this has received positive feedback.
- There is a wide variety in the number of complaints resolved locally across Wales. There have been no cases in RCT since March 2013.

December 2015

BRIDGEND COUNTY BOROUGH COUNCIL

REPORT TO STANDARDS COMMITTEE

26 JANUARY 2016

REPORT OF THE MONITORING OFFICER

APPOINTMENT OF VICE CHAIR

1. Purpose of Report

1.1 The purpose of this report is to seek the views of the Committee on the election of a Vice Chair.

2. Connection to Corporate Improvement Plan / Other Corporate Priority

2.1 Standards are an implicit requirement in the successful implementation of the Corporate Themes.

3. Background

3.1 The Standards Committee (Wales) Regulations 2001 provide that a Chairperson shall be elected from amongst the Independent members of the Committee. A Vice Chair is also advisable so that any absence of the current Chair can be covered.

4. Current Situation / Proposal

4.1 Aside from the current Chair, there are two Independent Members who are serving their first term of office and are eligible to act as Vice Chair.

4.2 The Standards Committee (Wales) (Amendment) Regulations 2006 permitted a second term of office for Independent Members, restricted to a maximum of 4 years. The current Chair will retire in February 2016 and therefore it is recommended that the Committee appoint a Vice Chair to ensure the proper operation of the Committee.

5. Effect upon Policy Framework& Procedure Rules

5.1 There is no effect upon the Policy Framework and Procedure Rules.

6. Equality Impact Assessment

6.1 There are no equality implications.

7. Financial Implications

7.1 None.

8. Recommendation

8.1 It is recommended that the Committee appoint a Vice Chair from amongst the Independent Members to take office from the date of this Committee meeting for a term to be determined.

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Background documents
None

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Regulation 21(1)(A) of the Local Authorities (Executive Arrangements) (Access to Information) (England) Regulations 2000.

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