**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

Our ref / Ein cyf:
Your ref / Eich cyf:

**Date / Dyddiad:** Friday, 5 February 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 **Thursday, 11 February 2016** at **2.00 pm**.

**AGENDA**

1. Apologies for Absence
To receive apologies for absence from Members.

2. Declarations of Interest
To receive declarations of personal and prejudicial interest (if any) from Members/Officers in accordance with the provisions of the Members' Code of Conduct adopted by Council on 1 September 2008.

3. Approval of Minutes 3 - 6
To receive for approval the Minutes of a meeting of the Standards Committee of 26 January 2016.

4. Local Government (Wales) Bill 7 - 20

5. Ombudsman's Casebook 21 - 82

6. Urgent Items
To consider any item(s) of business in respect of which notice has been given in accordance with Rule 4 of the Council's Procedure Rules, and which the person presiding at the meeting is of the opinion should by reason of special circumstances be transacted at the meeting as a matter of urgency.

7. Exclusion of the Public
The Minutes relating to the following item are not for publication as they contain exempt information as defined in Paragraph 12 of Part 4, and Paragraph 21 of Part 5 of Schedule 12A of the Local Government Act 1972, as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.

Tel/Ffôn: 01656 643643 Fax/Facs: 01656 668126 Email/Ebost: talktous@bridgend.gov.uk
SMS Messaging/Negeseuon SMS: 07581 157014 Twitter@bridgendCBC Website/Gwefan: www.bridgend.gov.uk

Text relay: Put 18001 before any of our phone numbers for the text relay service
Cyfnewid testun: Rhowch 18001 o flaen unrhyw un o'n rhifau ffon ar gyfer y gwasanaeth trosglwyddo testun

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

8. Approval of Exempt Minutes 83 - 84

To receive for approval the exempt Minutes of a meeting of the Standards Committee of 26 January 2016.

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

**Distribution:**

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

MINUTES OF A MEETING OF THE STANDARDS COMMITTEE HELD IN COMMITTEE ROOMS 2/3, CIVIC OFFICES ANGEL STREET BRIDGEND CF31 4WB ON TUESDAY, 26 JANUARY 2016 AT 2.00 PM

Present

Ms M Powell – Chairperson

Independent Members

Mrs B Heller
Mrs J Kiely
Mr Clifford Jones

Town/ Community Council Members

Mr RJ Hancock
Mrs A Davies

County Borough Council Members
Councillor RD Jenkins
Councillor DRW Lewis

Officers:

Andrew Jolley - Assistant Chief Executive Legal & Regulatory Services and Monitoring Officer
Laura Griffiths – Senior Lawyer
Kate Amos – Trainee Solicitor
Sarah Daniel – Democratic Services Officer - Committees

111. APOLOGIES FOR ABSENCE

None

112. DECLARATIONS OF INTEREST

None

113. APPROVAL OF MINUTES

That the minutes of a meeting of the Standards Committee of 17 September 2015 were approved as a true and accurate record of the meeting subject to the amendment of the Chairpersons title from Councillor to Ms.

114. WELSH GOVERNMENT CONSULTATION DOCUMENT - CONDUCT OF LOCAL GOVERNMENT MEMBERS

The Monitoring Officer provided a report to the Committee to advise them 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

The Monitoring Officer advised that 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 remained fit for purpose. The draft Statutory Instruments gave effect to this and related matters.

The Monitoring Officer advised Committee that the 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 and closed on 10 January 2016.

The Monitoring Officer stated that the key proposals which were pertinent to the work of the Standards Committee were:

- The Obligation to report potential breaches
- Constituency Interests
- Term of Office
- Joint Standards Committee
- Publication of misconduct Reports – Exemption
- Referral of misconduct cases
- Period of suspension
- Appeals to the Adjudication Panel for Wales
- Referral of Dispensation Applications
- Criteria for Granting Dispensations – Disability

Members welcomed the changes and were pleased that they had been reviewed as they felt it would remove many of the difficulties often presented to the Committee and Members of the Council

RESOLVED: That Committee noted the report.

115. OMBUDSMAN'S CASEBOOK

The Monitoring Officer submitted a report to Committee that provided a summary of cases that had been undertaken by the Ombudsman's Office from July 2015 to September 2015

Members stated that it was pleasing to see that Bridgend only appeared once in the casebook which gave them reassurance of a well-managed Authority.

RESOLVED: That the Committee noted the report.

116. STANDARDS CONFERENCE WALES 2015

The Monitoring Officer provided an update to the Committee from the Standards Conference Wales 2015 that took place on 19 October 2015 and was hosted by Cardiff City Council.

A member informed the Committee that the Conference was topical and well prepared with excellent workshops. She added it was interesting to meet members of other Standards Committees to share in their best practice.

RESOLVED: That the Committee noted the report.

117. APPOINTMENT OF VICE CHAIR

The Monitoring Officer submitted a report to the Committee and sought their views on the election of a Vice Chair. He advised Members that aside from the current Chair, there were two Independent Members who were serving their first term of office and were eligible to act as Vice Chair. He further advised that the current Chair was due to retire in February 2016 and therefore it was recommended that the Committee appoint a Vice Chair to ensure the proper operation of the Committee.

RESOLVED: That Mr Clifford Jones was elected as Vice Chair of the Standards Committee.

118. URGENT ITEMS

None

119. 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.

120. APPROVAL OF EXEMPT MINUTES

121. SHORTLISTING OF CANDIDATES FOR THE POSITION OF INDEPENDENT MEMBER ON THE STANDARDS COMMITTEE

The meeting closed at 2.45 pm

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**BRIDGEND COUNTY BOROUGH COUNCIL**

**REPORT TO STANDARDS COMMITTEE**

**11 FEBRUARY 2016**

**REPORT OF THE MONITORING OFFICER**

## LOCAL GOVERNMENT (WALES) BILL

### 1. Purpose of Report

1.1 To consider Part 4 of the Local Government (Wales) Bill, published by Welsh Government which relates to the Standards Committee.

### 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 Draft Local Government (Wales) Bill is the Minister for Public Services' version for Local Government in Wales and proposes fundamental reforms to the Local Government in Wales. The Bill closely aligns with the Well-being of Future Generations (Wales) Act 2015, the Social Services and Wellbeing (Wales) Act 2014 and the performance management framework for Local Government in Wales.

### 4. Current Situation / Proposal

4.1 The objective of the Draft Bill is to complete the programme of Local Authority Mergers and set out a new and reformed legislative framework for Local Authority democracy, accountability, performance, some elements of finance and establish a Statutory Public Service Staff Commission.

4.2 The Bill contains a range of legislative provisions relating to the governance of both County and Community Councils:

Part1 Local Government Areas and County Councils
Part 2 General Powers of Competence
Part 3 Promoting Access to Local Government
Part 4 Functions of County Councils and their Members
Part 5 County Councils Improvement of Governance
Part 6 Community Councils
Part 7 Workforce matters.

4.3 Part 4 of the draft Bill (attached as **Appendix 1**) proposes statutory duties upon the Members of the proposed new County Councils relating to the performance of their functions. Members would be placed under a statutory obligation to attend all relevant meetings, hold ward surgeries at least four times in every relevant 12 month period, answer correspondence sent to his/her official address within 14 days of receipt, complete all compulsory training courses and make an annual report. Leaders of political groups would be required to take reasonable steps to promote and maintain high standards of conduct by Members of their group.

4.4 Standards Committees would be given new functions to handle complaints that Councillors

have breached statutory duties imposed on them, and to monitor compliance of group leaders with the duties imposed on them and to advise on, and arrange, relevant training. Section 109 of the draft Bill place a duty on the Committee to make an annual report which will include the Committee's assessment of the extent to which Leaders of the political groups on the Council have complied with their duties.

4.5 Part 4 of the Bill also deals with the procedure for handling complaints about an alleged failure by a Councillor to abide by the duties imposed. The Monitoring Officer is required to refer the matter to the Chair of the Standards Committee. If the Monitoring Officer and the Chair both consider that a matter should not be investigated, no investigation may take place. If either the Monitoring Officer or the Chair considers it a matter that should be investigated, the Monitoring Officer must provide the Committee with a report of the investigation.

**5. Effect upon Policy Framework& Procedure Rules**

5.1 None.

**6. Equality Impact Assessment**

6.1 Consideration to equality issues is contained within the Draft Bill. There is an accompanying Equality Impact Assessment to the consultation document.

**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 and that any views of the Committee be forwarded to Welsh Government.


**Contact Officer:** P.A. JOLLEY
MONITORING OFFICER

**Telephone:** (01656) 643136

**E-mail:** andrew.jolley@bridgend.gov.uk

**Postal Address** Level 2 Civic Offices
Angel Street
Bridgend
CF31 4WB


**Background documents**
Consultation Documents, Local Government (Wales) Bill

Appendix 1



(4) In subsection (3)—

(a) after "constitution" insert "or, as the case may be, their constitution guide";

(b) for the words "who requests" to the end of the subsection, substitute "on request, either free of charge or at a charge representing no more than the cost of providing the copy".

**80 Duty on county councils to publish official addresses**

A county council must publish on its website, and in any other manner it considers appropriate, an official electronic and postal address for each member of the council, to which correspondence for the member may be sent.

## PART 4

## FUNCTIONS OF COUNTY COUNCILS AND THEIR MEMBERS

### CHAPTER 1

### OVERVIEW OF PART

**81 Overview**

In this Part—

(a) Chapters 2 to 4 impose duties upon members of a county council which relate to their performance, and make connected provision, including for the enforcement of those duties;

(b) Chapter 5 makes provision—

(i) for objectives to be set relating to the performance of an executive of a council operating executive arrangements;

(ii) for candidates for election as executive leader of a council to produce written manifestos;

(iii) for the appointment of assistants to executives where a council is operating executive arrangements;

(iv) for issuing guidance to elected mayors and executive leaders on equality and diversity;

(c) Chapter 6 makes provision—

(i) removing the requirement for a county council to designate a head of paid service and requiring instead that a chief executive be appointed for the council, whose functions will include duties imposed under that Chapter;

(ii) relating to the appointment of the head of democratic services of a county council, and a council's pay policy as it relates to that post;

(d) Chapter 7 makes provision—

(i) in respect of the meetings and functions of overview and scrutiny committees;

(ii) requiring standards committees to produce annual reports on the exercise of their functions;

(e) Chapter 8 makes minor amendments to the 2000 Act and the Local Government (Democracy) (Wales) Act 2013 (anaw 4).

5

## CHAPTER 2

## DUTIES ON MEMBERS OF COUNTY COUNCILS

*Performance duties*

### 82 Members of county councils to attend meetings

(1) A member of a county council must attend all relevant meetings.

10 (2) But a member is not in breach of the duty under subsection (1) if the member has a good reason for not complying with the duty.

(3) For the purposes of subsection (1), each of the following is a relevant meeting—

(a) a meeting of the county council of which the person is a member;

(b) a meeting of a committee or sub-committee of the county council, if the person is a
15 member of that committee or sub-committee;

(c) a meeting of any joint committee, joint board or other body of which the person is a member, if that committee, board or body is discharging any of the functions of the county council, or has been appointed to advise the council on any matter relating to the discharge of its functions;

20 (d) if a county council is operating executive arrangements and the person is a member of the executive, a meeting of the executive or of a committee of the executive of which the person is a member;

(e) any other meeting that the person would reasonably be expected to attend in the exercise of his or her functions as a member of the county council.

25 (4) Subsection (1) does not apply to a member of a county council who is exercising a right to a family absence under Part 2 of the 2011 Measure.

(5) Nothing in this section affects the operation of section 85 of the 1972 Act (vacation of office because of failure to attend meetings for six months).

### 83 Members of county councils to hold surgeries

30 (1) A member of a county council must hold a surgery at least four times in every relevant 12 month period.

(2) But a member is not in breach of the duty under subsection (1) if the member has a good reason for not complying with the duty.

(3) A member holds a surgery if the member makes himself or herself available for at least
35 one hour to meet members of the public to discuss matters in private.

(4) In complying with subsection (1), the member must ensure that the location, date and time of the surgery is published on the council's website and in any other manner he or she thinks appropriate more than seven days before the day of the surgery.

(5) For the purposes of this section, a relevant 12 month period is—

(a) the period of 12 months starting with the day on which the member assumes office as member of the council, and

(b) each subsequent period of 12 months.

(6) For the purposes of subsection (5), any period during which a member is exercising a right to a family absence under Part 2 of the 2011 Measure is to be disregarded; accordingly, the following two periods are to be treated as consecutive—

(a) any part of a 12 month period that falls immediately before the period of family absence, and

(b) the period that begins immediately after the period of family absence.

**84 Members of county councils to answer correspondence**

(1) A member of a county council must respond to all correspondence sent to his or her official address within 14 days of receipt.

(2) But a member is not in breach of the duty under subsection (1) if the member has a good reason for not complying with the duty.

(3) A member's "official address" is any address (whether postal or electronic) which is published by the council under section 80.

(4) This section does not apply to a member of a county council who is exercising a right to a family absence under Part 2 of the 2011 Measure.

**85 Members of county councils to complete training**

(1) A member of a county council must complete all compulsory training courses.

(2) But a member is not in breach of the duty under subsection (1) if the member has a good reason for not complying with the duty.

(3) Training is compulsory if the county council of which a person is a member has notified the person that he or she must complete it.

(4) This section does not apply to a member of a county council who is exercising a right to a family absence under Part 2 of the 2011 Measure.

*Duty to make an annual report*

**86 Members of county councils to make annual reports**

(1) A member of a county council must make a report—

(a) about his or her activities as a member of the council during the period of 12 months to which the report relates;

(b) setting out the results of those activities, if known to the member.

(2) A member of a county council must submit his or her report made under subsection (1) (an "annual report") to the county council's head of democratic services in accordance with the council's standing orders made by virtue of subsection (3)(b).

(3) A county council must specify in its standing orders—

(a) the period to which annual reports must relate, and

(b) when annual reports must be submitted to the head of democratic services.

(4) Standing orders made under subsection (3)(b) must not permit an annual report to be submitted after the end of the period of three months starting with the day of the annual meeting of the county council which follows the period to which the annual report relates.

(5) A county council must publish the annual reports submitted by its members.

## CHAPTER 3

## BREACHES OF DUTIES UNDER CHAPTER 2

*Possible breach of performance duties*

### 87 Complaints about a member's non-compliance with duties

(1) A person may make a complaint about a possible breach by a member of a county council of a duty imposed by section 82, 83, 84 or 85 to the monitoring officer of that council.

(2) A complaint under subsection (1) must be made in writing.

### 88 Deciding whether to investigate possible breach of performance duties

(1) If the monitoring officer of a county council—

(a) receives a complaint under section 87, or

(b) otherwise has reason to believe that a member has breached a duty under section 82, 83, 84 or 85,

he or she must refer the matter to the chair of the standards committee of the county council.

(2) The monitoring officer and the chair of the standards committee must together consider whether or not the matter should be investigated.

(3) When considering whether a matter should be investigated, the monitoring officer and the chair of the standards committee must consider—

(a) in cases where the monitoring officer has received a complaint under section 87—

(i) whether the complaint is frivolous or vexatious, and

(ii) whether the complaint relates to the same, or substantially the same, facts as a complaint that has already been disposed of, and

(b) in all cases, whether it is appropriate for the matter to be investigated.

(4) If either the monitoring officer or the chair of the standards committee consider that a matter should be investigated, the monitoring officer must investigate the matter.

(5) If the monitoring officer and the chair of the standards committee both consider that a matter should not be investigated, no investigation may take place; and, in cases where the monitoring officer has received a complaint under section 87, the monitoring officer must as soon as practicable take reasonable steps to—

(a) notify the person who made the complaint that the matter will not be investigated,

and

(b) give reasons for that decision.

(6) The monitoring officer and the chair of the standards committee may, for the purpose of deciding whether to investigate a matter, make such enquiries as they think necessary.

5 *Possible breach of duty to make annual report*

**89 Deciding whether to investigate possible breach of duty to make annual report**

(1) This section applies where the head of democratic services for a county council considers that a member of the county council may have breached the duty under section 86.

(2) The head of democratic services may—

10 (a) notify the monitoring officer of the council, who may investigate the matter;

(b) if the head of democratic services is also the monitoring officer of the council, investigate the matter (in the exercise of his or her functions as monitoring officer).

(3) When considering whether to conduct an investigation under this section, the monitoring officer must consult the chair of the standards committee of the county council on 15 whether it is appropriate for the matter to be investigated.

*Investigations, reports and sanctions*

**90 Investigation by monitoring officer**

(1) This section applies if the monitoring officer of a county council investigates a matter under section 88 (possible breach of performance duties) or 89 (possible breach of duty to 20 make annual report).

(2) The monitoring officer must give the member who is the subject of the investigation an opportunity to respond to the matter being investigated.

(3) The monitoring officer may—

(a) ask any person for information relating to the matter being investigated, and

25 (b) ask any person to assist him or her in conducting the investigation.

**91 Monitoring officer's report**

(1) After conducting an investigation under section 88 or 89, the monitoring officer of a county council must—

(a) provide the standards committee of the county council with a report on the 30 investigation,

(b) make any recommendations to the standards committee that the monitoring officer considers appropriate,

(c) send a copy of the report, and any recommendations made, to the member of the county council who was the subject of the investigation, and

35 (d) if the investigation results from a complaint under section 87, take reasonable steps to send a copy of the report, and any recommendations made, to the person who made the complaint.

(2) The standards committee must allow the monitoring officer to appear before it for the purpose of presenting the report and any recommendations made.

(3) The Welsh Ministers may by regulations make provision about the publicity to be given to reports and recommendations provided under this section.

5 **92 Consideration of matter by standards committee**

(1) This section applies if the standards committee of a county council receives a report from a monitoring officer under section 91.

(2) The standards committee must determine whether there is any evidence of a breach of the duty in question.

10 (3) If the standards committee determines that there is no evidence of a breach of the duty, it must—

(a) notify the member who is the subject of the report, and

(b) if the report results from a complaint under section 87, take reasonable steps to notify the person who made the complaint.

15 (4) If the standards committee determines that there is evidence of a breach of the duty, it must give the member who is the subject of the report written notice that he or she may make representations to the standards committee, either orally or in writing, in respect of the report.

(5) The standards committee may, for the purposes of exercising its functions under this
20 section—

(a) ask the monitoring officer to attend before it for the purposes of assisting it, and

(b) ask any person for information, or invite any person to make representations to it.

(6) The monitoring officer may not unreasonably refuse a request made under subsection (5).

(7) The standards committee must determine the period within which a member may make
25 representations under subsection (4); but the period must not be less than 28 days starting with the day on which the member is given notice under that subsection.

**93 Standards committee's determination**

(1) After the period determined under section 92(7) for making representations has ended, the standards committee must determine whether the member who is the subject of the
30 report under section 91 has breached the duty in question.

(2) If the standards committee determines that the member has breached the duty, it may decide to—

(a) censure the member,

(b) suspend or partially suspend the member from being a member of the county
35 council for a period not exceeding six months, or

(c) take no further action.

(3) The standards committee must—

(a) notify the member of its determination under this section, and of any action that will follow, and

(b) if the report results from a complaint under section 87, take reasonable steps to notify the person who made the complaint of those matters.

(4) The Welsh Ministers may by regulations make provision about the publicity that is to be given to any determination under this section and to any action taken against a member.

5 (5) The Welsh Ministers must by regulations make provision conferring rights of appeal on members of a county council against any determination of a standards committee under this section.

## CHAPTER 4

## FURTHER PROVISION ABOUT DUTIES ON MEMBERS

10 *Regulations and guidance relating to Chapters 2 and 3*

### 94 Regulations

(1) The Welsh Ministers may by regulations make further provision about the way in which a possible breach of a duty imposed by Chapter 2 is to be dealt with.

(2) Regulations under subsection (1) may, in particular, make provision—

15 (a) about matters to be taken into account in considering whether a possible breach of a duty should be investigated;

(b) about matters to be taken into account in determining whether a member has breached a duty;

(c) enabling a monitoring officer or a standards committee to refer a possible breach 20 of a duty, or any other matter that comes to the monitoring officer or the standards committee's attention in the course of an investigation, to the monitoring officer or the standards committee of another relevant authority;

(d) about procedures to be followed by a monitoring officer or a standards committee;

(e) about the disclosure of information;

25 (f) enabling sums to be paid to persons by way of expenses and allowances or costs;

(g) about how appeals are to be made, considered and determined.

(3) For the purposes of subsection (2)(c), a "relevant authority" means—

(a) a county council;

(b) a fire and rescue authority;

30 (c) a National Park authority for a National Park.

### 95 Guidance

A person exercising functions under Chapter 2 or 3 must have regard to any guidance issued by the Welsh Ministers.

*Related amendments*

35 ### 96 Standards committee to provide training

In section 54 of the 2000 Act (functions of standards committees), before subsection (3)

insert—

"(2B) A standards committee of a county council in Wales also has the specific function of advising, training or arranging to train members of the council on matters relating to the duties imposed by sections 82 to 86 of the Local Government (Wales) Act 2017 (duties to attend meetings, hold surgeries, answer correspondence, complete training and make annual reports)."

**97 Amendments to the 2011 Measure**

(1) The 2011 Measure is amended as follows.

(2) Section 5 is repealed.

(3) In section 7, after subsection (1), insert—

"(1A) A local authority must—

(a) consider whether it should be compulsory for its members to complete any training under section 85 of the Local Government (Wales) Act 2017, and

(b) in exercising its functions under subsection (1), secure the provision of any training which it is compulsory for a member to attend under section 85 of that Act."

*Role of leaders of political groups on county councils*

**98 Duties of leaders of political groups in relation to standards of conduct**

(1) The 2000 Act is amended as follows.

(2) After section 52 insert—

**"52A County councils: duties of leaders of political groups in relation to standards of conduct**

(1) A leader of a political group consisting of members of a county council in Wales—

(a) must take reasonable steps to promote and maintain high standards of conduct by the members of the group, and

(b) must co-operate with the council's standards committee (and any sub-committee of the committee) in the exercise of the standards committee's functions.

(2) In complying with subsection (1), a leader of a political group must have regard to any guidance issued by the Welsh Ministers.

(3) The Welsh Ministers may by regulations make provision for the purposes of this section about the circumstances in which—

(a) members of a county council in Wales are to be treated as constituting a political group;

(b) a member of a political group is to be treated as a leader of the

group.

(4) Before making regulations under subsection (3), the Welsh Ministers must consult such persons as they consider appropriate."

(3) In section 54 (functions of standards committees), after subsection (2) insert—

5 "(2A) A standards committee of a county council in Wales also has the specific functions of—

(a) monitoring compliance by leaders of political groups on the council with their duties under section 52A(1), and

10 (b) advising, training or arranging to train leaders of political groups on the council about matters relating to those duties."

35

**109 Duty of standards committee to make annual report**

In Part 3 of the 2000 Act, at the end of Chapter 1 insert—

**"56B Annual reports by standards committees**

(1) As soon as reasonably practicable after the end of each financial year, a standards committee of a relevant authority must make an annual report to the authority in respect of that year.

(2) The annual report must describe how the committee's functions have been discharged during the financial year.

(3) In particular, it must include a summary of—

(a) what has been done to discharge the general and specific functions conferred on the committee by section 54 or 56;

(b) reports and recommendations made or referred to the committee under Chapter 3 of this Part;

(c) action taken by the committee following its consideration of such reports and recommendations;

(d) notices given to the committee under Chapter 4 of this Part.

(4) An annual report by a standards committee of a county council in Wales must include—

(a) the committee's assessment of the extent to which leaders of political groups on the council have complied with their duties under section 52A(1) during the financial year;

(b) a summary of—

(i) matters referred to the chair of the committee under section 88 (possible breach of performance duties by members) of the Local Government (Wales) Act 2017, and

(ii) matters considered under section 92 of that Act (consideration by standards committee of possible breaches of duties), and determinations made under section 93 of that Act (standards committee's determination in relation to possible breaches of duties).

(5) An annual report by a standards committee of a relevant authority may include recommendations to the authority about any matter in respect of which the committee has functions.

(6) A relevant authority must consider each annual report made by its standards committee before the end of 3 months beginning with the day on which the authority receives the report.

(7) The function of considering the report may be discharged only by the relevant authority (and is accordingly not a function to which section 101 of the Local Government Act 1972 applies).

(8) In this section "financial year" means a period of 12 months ending with 31 March."

**BRIDGEND COUNTY BOROUGH COUNCIL**

**REPORT TO THE STANDARDS COMMITTEE**

**11 FEBRUARY 2016**

**REPORT OF THE MONITORING OFFICER**

**OMBUDSMAN'S CASEBOOK**

## 1. Purpose of Report

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

## 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 October 2015 to December 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.

**Contact Officer:** P A Jolley

Assistant Chief Executive Legal and Regulatory Services and Monitoring Officer

**Telephone:** (01656) 643106
**E-mail:** Andrew. Jolley@bridgend.gov.uk

**Postal Address** Level 2,
Civic Offices,
Angel Street,
Bridgend
CF31 4WB

**Background Documents**
None

# The Ombudsman's Casebook

Issue 23 January 2016

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Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

## A word from the Ombudsman

### New Year New Act?

Happy New Year! Whilst 2015 marked the 10th anniversary of the Public Services Ombudsman for Wales Act, 2016 marks the 10th anniversary of the office being created, an anniversary that we hope to celebrate shortly with an event at the Senedd where previous Ombudsmen, PSOW staff, Assembly Members and other stakeholders who've played a critical part in our success can come together.

The past year has provided an opportunity to take stock and to ensure that the office continues to serve the people of Wales well for the next decade.

Ever increasing workloads meant that last year we implemented the innovation review in order to improve our internal processes and procedures in order to generate additional capacity.

We also restructured the office, with a new Improvement role which we hope will help drive cultural improvements in complaint handling for some bodies in jurisdiction so that we see more good practice being adopted.

We will shortly be issuing a new thematic health report and also giving greater emphasis to data in improving public services.

We need legislative change to ensure that we are using all potential powers to drive improvement in public services so that we are:

(Continued overleaf)

- adopting good practice from other jurisdictions at home and abroad
- increasing capacity to deal with systemic failures
- providing new open data for greater scrutiny.

That is why I was delighted that the Assembly Finance Committee have committed to consult on a new PSOW Act. As I have said in previous editions of the Casebook, I think it's vital that we ensure that our legislative basis is sound and that we can claim to be genuinely fit for the future and that legislation:

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

I want new legislation that can provide:

**Own initiative investigations**
This is a power normally used sparingly to investigate where there is an obvious problem but no complaint has come forward or, more usually, to extend an investigation into a complaint to other bodies where it appears that the maladministration or service failure identified is likely to be systemic and affecting people other than the complainant. The Ombudsman in the Republic of Ireland already has such a power and it will shortly be introduced in Northern Ireland also. Outside of the UK, only five members of the Council of Europe have ombudsmen without own initiative powers.

**Complaint Standards Authority**
A few years ago, the Scottish Ombudsman was given the role of Complaints Standards Authority, an arrangement to be particularly effective in tackling problems in the standards of complaint handling within the bodies in his jurisdiction. There is a case for adopting such an approach in Wales so that any guidance I give to bodies on complaints handling has statutory force so that I can help support improvement in public sector complaints handling and produce date which can be used to scrutinise effectiveness.

**Access – oral complaints**
In the current legislation there is a requirement that all complaints should be in writing. Whilst the Ombudsman has discretion to accept a complaint in another form if appropriate, this has to be considered on a case by case basis. However, in view of the changing nature of electronic communication, and the considerable equalities issues about potentially excluding people who

cannot write, including, for example, people with learning disabilities, there is a case to be made for modernisation so that it is explicit in the legislation that complaints may be made orally.

**Extension and reform of Jurisdiction- Healthcare**
With an ever ageing society the integration of health and social care is an important part of public policy. Recently my jurisdiction was extended to include self-funded social care and hospice care; however I cannot investigate private healthcare, unless it was commissioned by the NHS.

Recently there was a case that I could not resolve where a patent had been treated by the NHS, then privately (self funded) and then again in the NHS. The patient sadly died. I was unable to investigate the private funded healthcare. Clearly there is a need to reform legislation where a patient chooses to be treated in both public and private sectors that the complaints process follows the citizen not the sector.

I hope that this year provides the opportunity to introduce new legislation with the cross party support of the National Assembly and that we can see the first ever Committee sponsored legislation in Wales. As new legislation for Northern Ireland receives Royal Assent and new legislation for England is anticipated, it's important that Wales isn't left behind.

Nick Bennett
Ombudsman

# Lessons Learnt

## GPs

While the majority of health complaints received by this office focus predominantly on clinical treatment in hospitals, complaints about GPs continue to appear in our Casebook on a regular basis.

GP services in Wales have been the subject of much press coverage of late, with the Royal College of GPs suggesting 400 more GPs are needed in Wales by 2020 to avoid a "deepening crisis." This has coincided with a recruitment drive for more junior doctors led by the Welsh Government's Health Minister Mark Drakeford.

In the final Casebook of 2015, two complaints against GPs were upheld.

In one case (201500550/201500551/201502099), a complaint was received by a health centre service user that GPs failings led to a delayed diagnosis of her rheumatoid arthritis leaving her with a permanent elbow disfigurement.

The Ombudsman concluded that "...had correct investigations been undertaken and the National Institute for Health and Care Excellence ("NICE") guidance on Rheumatoid Arthritis been followed, the patient might have been referred to a rheumatologist sooner than she was." The Ombudsman was also highly critical of the standard of the GPs' record-keeping.

The Ombudsman made a number of recommendations including asking the GPs to apologise for the failings identified in the report and make a redress payment. Amongst other recommendations, the GPs were asked to reflect on this complaint to ensure that they remained open to alternative diagnoses and possible referral.

In another case (201408459) the Ombudsman received a complaint regarding the assessment/ diagnosis and treatment provided by a GP to a patient. Specifically the patient complained that there had been a delay in diagnosing a cerebral aneurysm.

The Ombudsman found that the initial responses of the doctors had not been unreasonable although he said that there were some shortcomings. Taking account of clinical advice, he found that the records were insufficiently detailed and unclear about whether adequate and thorough neurological examinations had been performed.

He said that if the patient had a clear clinical plan in place a week earlier then some psychological distress and uncertainty might have been reduced during this time.

The Ombudsman made a range of recommendations including that improvements in assessment and record-keeping were implemented along with making sure the relevant doctor had the appropriate knowledge and skills to deal with such conditions in the future. The patient was clear

that she did not wish to receive an apology or financial redress from the Partners at the Practice. It's important to note not all complaints against GPs were upheld.

In one case (201409710) a complainant complained about the treatment and care of her brother, Mr Y, suggesting there had been a failure to follow up an initial chest x-ray and investigate symptoms of not eating, sleeping, lethargy and fatigue.

The investigation found that the care and treatment provided to Mr Y had been reasonable in the circumstances and, when there was a clinical indication, the tests and scans were appropriately followed up. The investigation also found that Mr Y's family had been offered appropriate support during the period in question.

In a further case, (201408950/201408954) Mrs M complained about the standard of care that her son, Mr A, received from his GPs and Cardiff and Vale University Health Board ("the Health Board") after he was discharged from hospital. Mrs M said that her son was ill enough to warrant being sectioned under the Mental Health Act or admitted as a voluntary patient to the psychiatric unit.

The Ombudsman's investigations concluded the care provided by the GPs was reasonable and appropriate and did not uphold this aspect of Mrs M's complaint.

In regards to the Health Board, the Ombudsman was critical that when Mr A started to voice concerns about his suicidal thoughts in October, his care was not escalated to a psychiatrist. Amongst the Ombudsman recommendations, the Health Board was asked to remind its clinical staff of the need to conduct suicide risk assessments.

Our factsheet sets out clearly what the Ombudsman can and can't do but ultimately GPs must ensure that they provide an acceptable standard of care and assessment.

As with all other service providers, GPs should always record their actions and be able to support their actions in the event that the matter requires investigation by this office.

**Key Questions**

Is the service received by the patient professional and thorough?

Have the findings of any examination or assessment been recorded accurately?

Are guidance materials fully accessible to a GP?

# Case Summaries

## Health

## Upheld

**Betsi Cadwaladr University Health Board - Clinical treatment in hospital**
**Case Reference 201404628 - Report issued in October 2015**
Mrs A complained that her brother, Mr B's, internal abscess was not diagnosed sooner, despite several attendances at the Emergency Department of Wrexham Maelor Hospital ("the Hospital") in October 2013. Mrs A also complained that there was a delay in receiving the initial complaints response from the Health Board and that it failed to respond to requests for additional information during the complaints process.

Having obtained professional advice, the Ombudsman upheld the complaint. The evidence and advice received confirmed that there were shortcomings in the assessments that were carried out at the Emergency Department and that important red flag features and clinical markers of sepsis, which would have mandated referral for imaging tests or an MRI scan and more than likely have led to earlier detection of Mr B's abscess, were overlooked. However, the Ombudsman was unable to conclude whether the delay in detecting Mr B's abscess had an adverse effect on the outcome. The Ombudsman also found communication failings in the Health Board's handling of Mrs A's complaint.

The Ombudsman recommended that the Health Board should:

a) provide an apology for the failings identified
b) make a payment of £1,000 in recognition of time and trouble and the distress caused to Mr B
c) review its complaints handling process to ensure that it meets with its obligations under "Putting Things Right"
d) take steps to improve its assessments in such cases.

**Aneurin Bevan University Health Board - Non-medical services – food, cleanliness**
**Case Number 201404515 - Report issued in October 2015**
Mrs C complained about her mother, Mrs G's, care and treatment by Aneurin Bevan Health Board ("the Health Board"). Mrs G was admitted to hospital on six separate occasions during September and November 2013, with symptoms including constipation, weight loss and vomiting. Mrs G was discharged on the first five occasions after initial exploratory procedures (including a non contrast CT scan) proved inconclusive and her condition had apparently settled. A CT scan performed in December 2013 identified that Mrs G had a duodenal stricture and a liver biopsy confirmed that she had cancer. Mrs C complained about the delay in diagnosing Mrs G's cancer and that this had impacted on her treatment. Mrs G was later referred for palliative care and sadly passed away on 14 May 2014.

The Ombudsman's investigation found there had been a failure by the Health Board to ensure that one Clinician had taken overall responsibility for Mrs G's treatment, given her multiple admissions, when she had been seen by different consultants who had failed to take responsibility for her condition. Further, no apparent consideration had been given to the risk/benefit of performing a contrast CT scan, notwithstanding her allergy (rash). This would have identified her cancer sooner, albeit that not many treatment options were available.

The Ombudsman concluded that, whilst not making a difference to the outcome for Mrs G, what happened demonstrated a failure to ensure consultant-led continuity that would have allowed the duodenal stent to be inserted earlier to relieve the intestinal obstruction.

The Ombudsman made the following recommendations, all of which the Health Board agreed to implement:

a) The Chief Executive should apologise in writing to Mrs C for the failings identified.
b) The Chief Executive should ensure that the case was presented and discussed at the next teaching "grand round" involving both gastroenterology and surgery teams. It should, within 20 working days thereafter, provide the Ombudsman with evidence to demonstrate that this has happened.
c) Every Consultant involved should reflect on Mrs G's case and, in particular, one of the Consultant Gastroenterologists should include the complaint in his next appraisal.

**Llwynhendy Health Centre - Clinical treatment outside hospital**
**Case Reference 201500550, 201500551 and 201502099 - Report issued in October 2015**

Ms M complained about the care and treatment she received from the GPs, Dr A, Dr B and Dr C at the Llwynhendy Health Centre ("the Health Centre"). She said that the GPs' failings had led to a delayed diagnosis of her rheumatoid arthritis leaving her with a permanent elbow disfigurement.

The Ombudsman's investigation recognised that rheumatoid arthritis was an uncommon condition and not a diagnosis that would be uppermost in a GP's mind. However, the Ombudsman said that a diagnosis of synovitis (inflamed lining of the joints) should have been considered and this would have prompted the investigations and assessments into rheumatism that should have been undertaken. He was of the view that, had correct investigations been undertaken and the National Institute for Health and Care Excellence ("NICE") guidance on Rheumatoid Arthritis been followed, Ms M might have been referred to a rheumatologist sooner than she was.

The Ombudsman was highly critical of the standard of the GPs' record-keeping. These clinical entries were extremely brief and on occasion had scant detail. This, coupled with the fact that Ms M was seen by a number of doctors in the practice, would not have allowed any of them to see "the complete picture". This may have contributed to the seriousness of Ms M's condition not being appreciated and the approximate five week delay in a referral to a rheumatologist.

The Ombudsman made the following recommendations:

a) the GPs should apologise to Ms M for the failings identified in the report and make a payment to Ms M of £350 for the distress caused to her by the failings identified

b) the Senior Partner should remind clinical staff of the need to follow the General Medical Council's guidance on record-keeping at an all staff meeting

c) the Senior Partner, at a meeting of clinical staff members, should reflect on how the Health Centre keeps up-to-date on NICE guidance relevant to general practice

d) the GPs should reflect on this complaint to ensure that they remained open to alternative diagnoses and possible referral.

**Betsi Cadwaladr University Health Board - Clinical treatment in hospital**
**Case reference 201405883 - Report issued in October 2015**
Mrs A was dissatisfied with the management and care that her mother, Mrs K, received at Abergele Hospital in 2013 following a fall. Mrs A was unhappy with a decision to only X-ray her mother's hip and not her lower back; Mrs A was subsequently found to have a fracture in her lower vertebra. Mrs A disagreed with Betsi Cadwaladr University Health Board's ("the Health Board") comment that her mother, who suffers from dementia, had shown no signs of pain after the fall. She was also concerned about the decision to discharge her mother three days after the fall.

The Ombudsman's investigation identified a lack of clarity in Mrs K's management and care which was compounded by very poor clinical documentation and ineffective communication. The Ombudsman had concerns about the adequacy of Mrs K's pain management. The nursing records showed Mrs K was in considerable pain after her fall.

However, the Ombudsman could not be definite about when Mrs K sustained the fracture to her back, and the decision not to X-ray her back was a sustainable clinical decision. The Ombudsman was highly critical of the Health Board's handling of Mrs A's complaint and its woefully inadequate complaint response.

The Health Board agreed to implement a wide range of recommendations including:

a) a review of Mrs K's failed discharge
b) dementia training for clinical staff on the orthopaedic ward
c) improved record keeping in the orthopaedic department; and
d) improved complaints handling within the Health Board.

**Cwm Taf University Health Board- Clinical treatment in hospital**
**Case reference 201405980 - Report Issued in November 2015**

Mr B complained that the care and treatment provided by Cwm Taf University Health Board ("the Health Board") in respect of his right knee fell below an acceptable standard. Mr B complained that the waiting times for knee surgery were unacceptable and that this overall health had been affected by the delays experienced.

Mr B also complained that a misdiagnosis of his condition caused further delay and the treatment associated with this diagnosis caused him to suffer toxic labrynthitis.

The investigation concluded that the exploration of the initial diagnosis and the attempt to treat this with medication was appropriate at the relevant time. Further on the basis advice received it could not be said that there was a link between the medication provided to Mr B and his subsequent development of toxic labrynthitis.

However, it was concluded that there were two distinct periods of unacceptable delay in the care and treatment provided to Mr B, which consequently, led to a delay in his right knee replacement surgery. During this period Mr B continued to experience pain.

Mr B's complaints were partly upheld.

In recognition of the failings identified the Health Board agreed to:

a) apologise to Mr B

b) make a redress payment of £750 in recognition of the pain suffered, distress caused and a further £250 for his time and trouble in pursuing his complaints, and

c) conduct an analysis of the care provided, including a consideration of what lessons might be learned and how those learning points will be addressed for the future.

**Betsi Cadwaladr University Health Board – Clinical treatment in hospital**
**Case Reference 201408391 - Report issued in November 2015**

The Ombudsman investigated a complaint about the management of Mr A's late wife's diverticulitis and the subsequent delay in diagnosing her cancer.

The Ombudsman found that Mrs A had received appropriate tests and treatment for her symptoms, which were reasonably diagnosed as diverticulitis. Mrs A's cancer had been extremely difficult to diagnose and once diagnosed she received the appropriate treatment.

Any uncertainty about the location of the cancer did not affect her treatment or the sad outcome.

However, the Ombudsman was critical of delays in the Health Board responding to the complaint and recommended the Health Board:

a) apologise to Mr A
b) pay Mr A the sum of £750 in recognition of the time and trouble to which he had been put in pursuing his complaint.
c) Improve their complaint handling processes.

**Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital**
**Case Reference 201405342 - Report issued in November 2015**
Mrs A complained about her late husband's care and treatment at Abertawe Bro Morgannwg University Health Board's ("the Health Board") Morriston and Singleton Hospitals. Mrs A was also dissatisfied that changes in Mr A's heart indicative of a heart attack had not been reported by the radiologist. Sadly, some months later, Mr A died of a heart related condition shortly after being admitted as an inpatient. Finally, Mrs A was dissatisfied with the way that the Health Board dealt with her complaint.

The Ombudsman's investigation found that overall Mr A's care and treatment had been reasonable. Although the abdominal scan had shown evidence of significant heart disease non-cardiac radiologists would have been unlikely to have identified it. While this aspect of Mrs A's complaint was not upheld, the Ombudsman did uphold Mrs A's complaint about the Health Board's handling of her complaint having identified shortcomings including delay.

The Ombudsman's recommendations included:

a) a review of Mr A's scan to disseminate learning amongst non-cardiac specialists in the Health Board's radiology team.
b) an apology from the Health Board's Chief Executive should apologise for the failings in complaint handling and make a payment to Mrs A of £500.

**Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital**
**Case Reference 201404662 – Report issued in November 2015**
Mrs X complained that in 2010, she had a CT scan which showed kidney stones; however they were not identified and this was a misdiagnosis. In January 2013, Mrs X's kidney stones were identified. Mrs X said the first opinion recommended a conservative approach and that keyhole surgery was not an option. Mrs X said that the second opinion had been that a conservative approach was inadvisable. Mrs X complained that had a surgical approach been adopted, it may have prevented suffering and the removal of 40-50 kidney stones. Mrs X complained that her severe abdominal pain was incorrectly attributed to her spine and her symptoms were incorrectly diagnosed as gynaecological. Mrs X also complained about the Health Board's complaint procedure.

The Ombudsman's Adviser said that Mrs X's 2010 CT scan showed calcified opacities, they were not identified as renal stones. Mrs X had then presented with symptoms considered to have been spinal as opposed to renal stones. The Adviser had no criticism of this as small opacities are common in abdominal scans. Mrs X's case presented reasons for a cautious approach to surgery due to her size (BMI 33), several previous abdominal operations and a large para-stomal hernia. The conservative management plan adopted consisted of laser and ultrasound treatment, which caused the renal stones to fragment (40 - 50 kidney stones). The second opinion was that it was then preferable for surgery. The Adviser had no criticism of this approach. These aspects of the complaint were not upheld.

The Adviser said that Mrs X's symptoms were sufficient to suggest her symptoms were related to a lumbar spine problem. The Adviser said that Mrs X was correctly referred to a gynaecologist. These aspects of the complaint were not upheld.

The Health Board accepted that Mrs X's complaint had not been handled in an appropriate manner and offered to pay £250 as a reflection of its poor complaints handling. This aspect of the complaint was upheld, with no recommendation made as the Health Board had already put in place positive changes to its complaints management.

**Betsi Cadwaladr University Health Board – Clinical treatment in hospital**
**Case Reference 201502101 – Report issued in November 2015**

Mr A complained about the care his wife received at Ysbyty Gwynedd for a cut to her head. Mr A complained that the cut was not properly treated causing the wound to worsen and become infected. Mr A said that Mrs A then had to have regular home visits for five weeks to clean and re-dress the wound. Mr A also complained that Betsi Cadwaladr University Health Board ("the Health Board") took a total of 18 months to reply to his complaint.

The Ombudsman found that it was not possible to say whether the wound had become infected, but concluded that it had not been properly assessed before discharge. The Ombudsman also found that the Health Board's complaint handling had been woeful.

The Ombudsman upheld the complaint and recommended that the Health Board should:

a) apologise to Mr and Mrs A
b) pay Mr and Mrs A financial redress of £1000 in respect of both the uncertainty as to whether, but for the failings identified, the recovery period might have been shorter and the inordinate delay in complaint handling
c) remind relevant staff of the need for comprehensive injury assessments
d) remind relevant staff of the need for comprehensive entries in patient records
e) review its complaint handling procedure to ensure that complainants receive explanations for any delayed responses.

**Betsi Cadwaladr University Health Board - Other**
**Case Reference 201404585 - Report issued in November 2015**

Mrs X complained about the care and treatment her brother, Mr Y, received during his admission to hospital in April 2010. Specifically, Mrs X complained about the failure to diagnose and treat Mr Y's recently fractured hip, poor communication with family, and the inadequate attention given to Mr Y's physiotherapy. Mrs X also complained that there was a failure to respond to her letters of complaint.

The investigation found that given Mr Y's complex medical history the delay of one day to diagnose his broken hip was reasonable. However there was concern that when reaching a view on Mr Y's injuries and treatment plan, poor quality X-rays and scans were used. The investigation also found that there had been a failure to carry out necessary physiotherapy and as a result Mr Y was no longer able to stand, walk, sit unaided or feed himself. Finally the investigation found that Betsi Cadwaladr University Health Board ("the Health Board") failed to respond to Mrs X's letters of complaint in a timely manner.

It was recommended that the Health Board should:

a)apologise to Mr Y and Mrs X for the failings identified
b)negotiate with Mrs X, as Mr Y's representative, a suitable figure of redress in recognition of those failings. It was also recommended that the Health Board remind
c)ensure that diagnosis and treatment decisions are based on good quality scans and X-rays and, where appropriate, seek a second opinion and remind clinicians to share information where appropriate
d)review its procedures and asked the relevant clinician to reflect on the case and provide Mrs X with a full explanation.

**Aneurin Bevan University Health Board – Clinical treatment in hospital**
**Case Reference 201405048 - Report issued in November 2015**

Mrs X complained about the care and treatment her husband, Mr X, received during his admission to hospital. Specifically, poor communication, a failure to identify Mr X's oral thrush, a failure to keep Mr X hydrated and nourished and a failure assist him following a call for help. Mrs X also complained that there was a failure to scan and monitor Mr X's kidney and liver functions and provide suitable palliative care.

The investigation found that communication with Mr X and his family was poor and that Mrs X and her family did not understand the extent of Mr X's illness or the consequences of any findings. The investigation also found that there had been a failure to conduct oral assessments and assist Mr X to meet his oral hygiene needs. As a result, the opportunity to diagnose and treat Mr X's oral thrush earlier was lost. Finally, the investigation found that fluid and nutrition charts were not always completed and despite a period of sickness and diarrhoea there was a failure to give Mr X the bath he requested.

It was recommended that Aneurin Bevan University Health Board Health Board:

a) apologise to Mrs X
b) pay her the sum of £500 in recognition of the service failure identified in the report.
c) outline what action it has taken to remind the relevant staff of the importance of good communication with a patient's relatives and the need to ensure that a patient feels that dignity has been maintained at all times
d) remind the relevant staff of the obligations to complete an oral hygiene assessment for new patients and the need to review that assessment regularly and provide relevant staff with refresher training on record keeping.

**Abertawe Bro Morgannwg University Health Board – clinical treatment in hospital**
**Case Reference 201405254 – report issued in December 2015**
Ms D complained that post-operative bleeding that occurred following a hip replacement operation that she underwent at Morriston Hospital was caused by failings in the pre and post-operative anticoagulation treatment that she received. Ms D complained that as a result of these failings, she suffered wound dehiscence and underwent four surgical washout procedures before her wound adequately healed. This necessitated Ms D remaining in hospital for a period of eight months.

The Ombudsman found that there was no evidence to suggest that clinicians incorrectly administered Ms D's anticoagulation medication or mismanaged her condition. However, he also found that:

a) there was insufficient involvement of a senior consultant haematologist in the management of Ms D's anticoagulation treatment
b) such management was largely left to junior doctors who occasionally struggled with the complexity of Ms D's condition
c) there was a concerning absence of any effective escalation policy by which nurses or junior doctors could refer problems to more senior doctors at weekends
d) there was a concerning absence of routine reviews of orthopaedic patients at weekends
e) there was a very poor standard of medical record keeping
f) Ms D experienced a delay in receiving an appropriate blood transfusion
g) there were failings in Abertawe Bro Morgannwg University Health Board's ("the Health Board") handling of Ms D's complaint.

The Ombudsman recommended that the Health Board should:

a) provide a fulsome, written apology to Ms D that recognises the seriousness of the failings identified in the report and which acknowledges the distress and anxiety caused to Ms D as a result

b) in recognition of the injustice these failings gave rise to and in recognition of the excessive delay in dealing with Ms D's complaint, makes a payment to her in the sum of £750

c) demonstrate that it has conducted, as a matter of urgency, a review of the medical establishment of the Orthopaedic Department at Morriston Hospital which focuses on the ratio of senior to junior physicians and on the level of senior medical review available for patients on weekends and bank holidays

d) remind orthopaedic clinicians of the need to involve senior haematologists in the peri-operative management of patients receiving oral anticoagulants where such patients prove difficult to stabilise. The reminder should specify the pathways by which junior doctors and nurses can escalate such problems to senior clinicians

e) ensure that, in selecting a senior clinician to review the clinical aspects of a complaint about care and treatment, they have no direct connection to, or responsibility for, the personnel or matters complained of

f) take immediate steps to ensure that GMC guidance on good record keeping is brought to the attention of all relevant clinicians within the Orthopaedic Department and provides the Ombudsman with documentary evidence of how this process was accomplished

g) carry out an audit to show record keeping within the Orthopaedic Department has improved and meets national guidelines.

**Glynneath Dental Practice – clinical treatment outside hospital**
**Case reference 201500814 - report issued in December 2015**
Mr B complained that, following a series of dental extractions that he underwent at Glynneath Dental Practice ("the Practice"), he was provided with an immediate, acrylic denture that was ill-fitting and, in his view, poorly made. Mr B complained that, despite returning to the Practice on four occasions to complain that the denture was loose, dentists were unable to satisfactorily adjust it. Mr B further complained that the Practice declined to refund the charges he incurred for the denture and informed him that he would be charged for a new denture that he would need when his gums fully healed in 3-4 months. Mr B complained that he had not been informed of this additional charge at the outset of his treatment.

The Ombudsman found that it is commonly the case that patients receiving immediate dentures return to the dentist to have adjustments made to it after initial fitting. The Ombudsman also found that Mr B was forewarned that adjustments to the denture would be needed in the short term and that a new denture would be needed at the end of the healing process.

However, the Ombudsman upheld Mr B's complaint that he was not explicitly informed at the outset of his treatment that he would be required to pay for any replacement denture.

a)The Ombudsman recommended that the Practice should introduce a system of providing written advice to patients having immediate dentures to inform them of the need for subsequent

adjustments, rapid deterioration in the fit of the denture and the need for early replacement. This advice should make explicit that additional costs may be incurred. The Practice should retain a signed copy of it as part of the consent process.

**Betsi Cadwaladr University Health Board – clinical treatment in hospital**
**Case reference 201406084 - report issued in December 2015**

Mrs X complained about the care and treatment her late husband, Mr X, received from Betsi Cadwaladr University Health Board ("the Health Board"). Mrs X said that there were unnecessary delays in Mr X being seen by a doctor and moved to the Medical Assessment Unit ("MAU"); there was a failure to adequately monitor Mr X during his admission to the Emergency Department; that the out of hours GP's decision to send Mr X home was unreasonable; that there was a failure to consider Mr X for a liver transplant in 2009; that there was a delay in administering adequate pain relief and starting palliative care and finally that there was a failure to respond to Mrs X's letters of complaint.

The investigation found a delay in Mr X seeing an emergency doctor and then being reviewed by the Medical Team, this resulted in Mr X's pain continuing and his condition deteriorating. The investigation also found a delay in referring Mr X for palliative care. Finally the investigation found that Mrs X's complaint had not been dealt with in accordance with the Health Board's complaint procedure.

It was recommended that the Health Board should:

a) provide Mrs X with an apology
b) pay Mrs X £300 in recognition of the time and trouble she experienced
c) remind relevant staff of the need for accurate record keeping and include record keeping on its training plan
d) produce a policy for the review of medical and surgical patients in A&E when bed pressures lead to delays in patients reaching MAU
e) undertake a best practice review of managing high pressures in the Emergency Department and on the MAU, and
f) conduct a multi-disciplinary review of this case and the lessons learned and where appropriate produce an action plan.

**Hywel Dda University Health Board – clinical treatment in hospital**
**Case reference 201503905 - report issued in December 2015**

Mr Y's wife was diagnosed with an abnormal heart rate, and in need of a pacemaker. Mr Y complained about the subsequent delay of five weeks in arranging her transfer from Withybush Hospital to a hospital in a neighbouring Health Board area for the pacemaker to be fitted. Mr Y also complained about the time taken (approximately four months) to diagnose Mrs Y with dementia following a referral to the memory clinic.

The Ombudsman upheld the complaint. Mrs Y should not have been categorised as "non-urgent", and the documentation of the referral and subsequent "chasing up" of it was not clear. The delay

of five weeks for the fitting of an urgent pacemaker was unacceptable. The period Mrs Y spent in hospital contributed to the delay in the diagnosis of dementia. However, there was no evidence that Mrs Y's cardiac condition deteriorated because of the delay, and it could not be said that the protracted stay in hospital had any ultimate effect on the extent of Mrs Y's mental deterioration.

The Ombudsman was satisfied that Hywel Dda University Health Board ("the Health Board") had introduced procedures to address the failings identified. He recommended that the Health Board should:
a) apologise to Mr and Mrs Y, and
b) make a payment of £600 in recognition of their distress.

**Hywel Dda University Health Board – clinical treatment in hospital**
**Case reference 201408108 - report issued in December 2015**
Mr A complained that while in hospital under the Mental Health Act he received five injections of the antipsychotic drug Clopixol Acuphase ("Acuphase"). Mr A said that after each injection he experienced severe side effects which included him being unable to walk due to considerable pain in his leg. Mr A said that staffs were aware of the side effects the injections were having on his mobility but continued administering the injections.

The Ombudsman's investigation found that Mr A's clinical records showed that he was only given three doses of the Acuphase injections and not five as he suggested. I have therefore not upheld this aspect of his complaint.

However, the Ombudsman was critical that there was a failure by the Consultant Psychiatrist to have explored alternative treatment methods or, if any were considered, there was a failure to record such consideration. I have upheld Mr A's complaint to that limited extent.

The Ombudsman recommended that:

a) the report be shared with the Consultant Psychiatrist as part of an appropriate peer review, and;
b)Hywel Dda University Health Board, as part of its teaching and mentoring programme, should encourage medical staff to consider and record alternative options.

**Hywel Dda University Health Board – Clinical treatment in hospital**
**Case Reference 201500389 - report issued in December 2015**
Mrs A complained about the care of her daughter (Mrs B) during the latter stages of her pregnancy. She complained that Hywel Dda University Health Board ("the Health Board") staff should have intervened earlier to deliver Mrs B's baby, given her extreme abdominal swelling and discomfort. Mrs A argued that the delay had put the health of Mrs B and her baby at potential risk. Mrs A also complained about the delay in the handling of her complaint.

After examining Mrs B's clinical records, and seeking professional advice from an obstetric adviser to the Ombudsman ("the Adviser"), the complaint about clinical care was not upheld. The Adviser explained that pregnancy oedema (responsible for Mrs B's abdominal swelling) was common. Whilst

acknowledging Mrs B's discomfort, tests to rule out other more serious root causes (which might have justified intervention) had been performed and many diuretics are harmful to the unborn baby. Clinicians assess the relative risks to both mother and baby in deciding whether to intervene, as babies born early often have respiratory difficulties. Good practice guidance had been followed in Mrs B's case. Once the risk proved greater to Mrs B, owing to her distress and discomfort, the baby was safely delivered by Caesarean section.

The Ombudsman upheld the complaint handling issue and made the following recommendations, which the Health Board accepted:

a) to apologise to Mrs A for the delay in dealing with her complaint

b) to offer Mrs A the sum of £100 for that delay and her resulting time and trouble in pursuing her grievances.

**Hywel Dda University Health Board- clinical treatment in hospital**
**Case reference 201404436 – report issued in December 2015**

Mrs C complained about the care and treatment she received from Hywel Dda University Health Board ("the Health Board") during and after the birth of her second child, in particular that it had not taken steps to adequately investigate or treat symptoms (severe headache, impaired vision and blackouts) she had experienced since then. Mrs C also complained that the Health Board's response to her complaint was inadequate and subject to unacceptable delay.

The Ombudsman found that the actions of clinicians during Mrs C's childbirth were appropriate in the circumstances. The investigations that had taken place since then into her symptoms were appropriate, as was the ultimate diagnosis of primary headache syndrome and a functional neurological disorder. However, there was a failure to offer appropriate treatment to Mrs C for her functional disorder. There had also been, as the Health Board had itself accepted, an unacceptable delay in dealing with Mrs C's complaint as the Health Board had wrongly thought she was going to take legal action. Mrs C's complaints were partly upheld.

The Ombudsman recommended that the Health Board should:

a) apologise for the failings identified, pay Mrs C £500 for the injustice caused by the lack of treatment and £500 for the mishandling of her complaint
b) that Mrs C be referred for assessment and potential treatment of her functional disorder, and
c) provide evidence of services it has in place for patients with functional disorders.

**A GP Practice in the area of Hywel Dda University Health Board – clinical treatment outside hospital**
**Case reference 201408459 - report issued in December 2015**

Mrs X complained about the assessment/diagnosis and treatment provided by the GP Practice. Specifically she complained that there had been a delay in diagnosing a cerebral aneurysm. Mrs X said she had previously seen the Doctors complaining of headaches and was of the view that if the

Doctors had sent her for earlier tests, the aneurysm would have been found and she could have received treatment for this.

The Ombudsman found that the initial responses of the Doctors had not been unreasonable although he said that there were some shortcomings. Taking account of clinical advice, he found that the records were insufficiently detailed and unclear about whether adequate and thorough neurological examinations had been performed. The Ombudsman however noted that it would be most unlikely that Mrs X's aneurysm would have been identified even with optimal assessment and examination by the Practice Doctors.

The Ombudsman also found that an earlier referral to a Neurologist was indicated as Mrs X's headaches had been present for some time and had not responded to treatment. He said it was a significant shortcoming that this did not take place. The Ombudsman noted however that there was nothing obvious to suggest that an urgent referral/acute hospital admission was required and he said that the timing of a routine referral would not have influenced the unfortunate course of events for Mrs X.

The Ombudsman found that the shortcomings did lead to some injustice for Mrs X. He said that if Mrs X had a clear clinical plan in place a week earlier then some psychological distress and uncertainty might have been reduced during this time. He was also of the view that there remained a very small, element of doubt about whether something could have been picked up earlier due to the limitations in the recording.

The Ombudsman partly upheld Mrs X's complaint to the extent of the shortcomings identified.

The Ombudsman made a range of recommendations including that improvements in assessment and record keeping were implemented along with making sure the relevant Doctor had the appropriate knowledge and skills to deal with such conditions in the future. Mrs X was clear that she did not wish to receive an apology or financial redress from the Partners at the Practice.

**Aneurin Bevan University Health Board - Health - Clinical treatment in hospital**
**Case reference 201404388 – Report issued in December 2015**
Mr X complained about the standard of care provided to his partner, Ms Y, who has borderline personality disorder, by the Health Board's mental health service. In particular, he was concerned about the appropriateness of the care and treatment provided, the standard of communication with him, and delays in Ms Y's care being transferred to an alternative provider.

The Ombudsman found that the standard of care was broadly good, in what was a complex case. He did make some criticisms in relation to the assessment of Ms Y's mental capacity on some occasions, communication, and the basis for Ms Y remaining in hospital as an informal patient for a particular period. He partly upheld the complaint. The Ombudsman recommended that the Health Board apologise to Ms Y and Mr X for the failings identified, provide additional training for ward staff on managing patients with borderline personality disorder, and develop standards for communication between the various mental health services.

**Abertawe Bro Morgannwg University Health Board - Health - Clinical treatment in hospital**
**Case reference 201409395 – Report issued in December 2015**
Ms D complained about a number of aspects of the care provided to her father by Abertawe Bro Morgannwg University Health Board ("the Health Board") from 25 February 2014 until his sad death on 31 March. These included concerns about delays in Mr D's surgery and in arranging a CT scan and contradictory information she said she was given regarding her father's chest infections. Ms D also questioned whether adequate oral care had been given to Mr D and whether he should have been on the sepsis pathway. Ms D raised concerns about whether Mr D's surgical wound was managed appropriately; the follow up from the CT scans and delays in the death certificate being signed. Ms D also raised concerns about the handling of her complaint by the Health Board.

The Ombudsman found that Mr D's surgery and CT scan were carried out within a reasonable timeframe. As there was no record of what Ms D had been told regarding Mr D's chest infections, the Ombudsman could not say she had not been given conflicting information. He upheld the complaint. He was also critical of the standard of record keeping, particularly in relation to discussions with the family about prognosis. The Ombudsman was satisfied that Mr D received appropriate and timely treatment for an oral hygiene issue and found that there was no clinical indication for Mr D to have been on the sepsis pathway. The Ombudsman found that follow up from CT scans would not usually have been given as the results were normal and the death certificate was issued within the usual timescales. Mr D's wound was managed appropriately.

In relation to complaint handling, the Health Board accepted that the complaint should have been dealt with sooner. It offered to meet with the complainant and make a payment of £250. The Ombudsman considered this reasonable and Ms D accepted the payment.

The Ombudsman recommended that the Health Board should:

a) write to Ms D to apologise for the identified shortcomings.
b) remind all relevant clinical staff of the need to record, with sufficient detail, all discussions with relatives in the records, particularly in relation to discussions regarding prognosis.
The Health Board accepted the Ombudsman's recommendations.

**Hywel Dda University Health Board - Clinical treatment outside hospital**
**Case reference 201500885 –Report issued in December 2015**
Mrs S complained about the standard of care provided to her adult son, Mr B, when he was assessed on three occasions by the local Community Mental Health Team ("CMHT") following referral by his GP. On each occasion he was deemed not to need services from CMHT and that any mental health symptoms resulted from Mr B's substance misuse rather than ongoing mental illness. He was subsequently sectioned under the Mental Health Act.

The Ombudsman found that on the basis of the content of the first two assessments, the CMHT conclusion that there was no need for ongoing CMHT input was reasonable given Mr B's presenting symptoms. However, at the time of the third assessment, additional information and the persisting nature of the symptoms, were ignored by CMHT.

The Ombudsman found that staff stuck too rigidly to their view that all symptoms were related to ongoing drug use, rather than considering all the available evidence as a whole. Staff did not appear to consider that there are occasions when drug-induced psychosis becomes persistent (even when drugs are absent) and mental illness develops. He also found that there was no joint working between Mental Health and Learning Disability teams. The Ombudsman upheld Mrs A's complaint. He recommended that, as well as apologising to Mrs A, the Health Board should ensure that it had an effective protocol/procedures in place to ensure effective joint working between Mental Health and Learning Disability teams. He also recommended training for staff in drug-induced schizophrenia.

## Not Upheld

**A dentist in the area of Abertawe Bro Morgannwg University Health Board – Clinical treatment outside hospital**
**Case Reference 201502299 – Report issued in October 2015**
Mr T complained about the standard of dental treatment provided to him. In particular, he was concerned about the treatment decision to restore several teeth, rather than to extract them. Some of the restored teeth subsequently cracked and required extraction anyway. Mr T incurred a charge for this further treatment. Mr T complained that these teeth should have been extracted in the first instance.

The Ombudsman found that the dental treatment provided to Mr T had been entirely reasonable. The Ombudsman noted that Mr T had to pay for the extraction of the teeth, but this related to a change in Mr T's income and therefore his entitlement to free NHS dental care, rather than the treatment decision. He did not uphold the complaint.

**Powys Teaching LHB – Continuing Care**
**Case Reference 201501657 - Report issued October 2015**
A firm of solicitors complained on behalf of Miss X about Powys Teaching Local Health Board's ("the Health Board") consideration of her retrospective claim for NHS funded continuing healthcare ("CHC") for her late mother, Mrs X, from 1 March 2007 to 29 November 2010. The firm of solicitors said that the decisions of the clinical adviser and the Independent Review Panel ("IRP") were flawed. They considered that the IRP did not take full account of all of the evidence available and that a proper explanation of the outcome of the IRP had not been provided.

The Ombudsman found that the LHB had followed the procedure set out in Welsh Government Guidance; had considered all the available evidence; had applied the relevant tests in reaching its decision that Mrs X was not eligible for CHC for the period in question and had set out a rationale for its decision. As there was no evidence of maladministration in the LHB's consideration of the claim, the Ombudsman did not uphold the complaint.

**Powys Teaching LHB – Continuing Care**
**Case Number 201405450 - Report issued October 2015**
Mrs X, via her solicitor, complained that Powys Teaching Local Health Board's ("the Health Board") Retrospective Special Review Panel ("the Panel")was wrong to conclude that her late uncle, Mr W, was not eligible to receive continuing NHS funded healthcare ("CHC") while he resided at a Nursing Home between 12 December 1996 and 19 June 2001. Mrs X complained that the Panel:

a) failed to recognise that Mr W's long term nursing care needs met the criteria for CHC funding
b) failed to take account of the Health Board's Clinical Adviser's recommendation that Mr W met CHC funding eligibility criteria for a limited period in which he exhibited unpredictable behaviour
c) failed to act in accordance with the provisions of the National Framework for Continuing Healthcare in determining that, whilst Mr W's behaviour was unpredictable, the degree of unpredictability did not constitute a primary health need. Mrs X argued that the Framework requires only that unpredictability is identified and does not distinguish between degrees of unpredictability.

The Ombudsman found that the LHB had followed the procedure set out in Welsh Government Guidance; had considered all the available evidence, including the views of the Health Board's Clinical Adviser; had applied the relevant tests in reaching its decision that Mr W was not eligible for CHC for the period in question and had set out a rationale for its decision. Whilst the Ombudsman was critical of the Panel's recording of its deliberations (which at times lacked detail), this shortcoming did not suggest that the Panel's decision on the claim was wrong.

The Ombudsman did not therefore uphold the complaint.

**Cardiff and Vale University LHB – Clinical treatment in hospital**
**Case Reference 201404665 - Report issued October 2015**
Mrs X complained about the care and treatment that her late husband, Mr X, received following surgery to a fracture of his upper arm bone. Specifically, that there was a delay in conducting an angiogram to identify the source of Mr X's arterial bleeding, and as a result there was a delay in treating the wound with cauterisation.

The investigation found that Mr X's initial surgery was undertaken without complication and that his care and treatment was reasonable. The investigation also found no evidence of unnecessary delay in referring Mr X for an angiogram. Finally the investigation found that at an earlier attempt to cauterise Mr X's wound would have placed him at risk. The Ombudsman therefore did not uphold the complaint.

**A GP in the area of Cwm Taf University Health Board – Clinical treatment outside hospital**
**Case Reference 201409710- Report issued October 2015**
Mrs X complained about the care and treatment her brother, Mr Y, received from a GP in the area of Cwm Taf University Health Board. Mrs X complained that there had been a failure to follow up on Mr Y's initial chest X-ray, investigate his symptoms of not eating, sleeping, lethargy and fatigue and undertake blood tests without being asked by a member of the family. Mrs X said that, as a result, there had been a failure to diagnose Mr Y's serious lung condition until it was too late to be treated. Mrs X also complained that there had been a failure to refer Mr Y to hospital for an investigation of his swollen feet and legs and listen to the family's requests for help.

The investigation found that the care and treatment provided to Mr Y had been reasonable in the circumstances and, when there was a clinical indication, the tests and scans were appropriately followed up. The investigation also found that Mr Y's family had been offered appropriate support during the period in question. The complaint was not upheld.

**Powys Teaching Health Board – Continuing Care**
**Case Number 201404035- Report issued October 2015**
Mrs B complained that Powys Teaching Health Board ("the Health Board") had contributed to the delay associated with the determination of her retrospective claim for NHS funded continuing care. She had made this retrospective claim via her solicitor, on behalf of her aunt, Miss A.

The Ombudsman was not persuaded, given the policy context; the transitional status of Mrs B's application and the evidence before him, that the Health Board had delayed the determination of Mrs B's retrospective claim. He did not uphold Mrs B's complaint.

**Cardiff and Vale University LHB – Clinical treatment in hospital**
**Case Reference 201408900 – Report issued in November 2015**
Mrs E complained about the standard of treatment provided to her son, F, by Cardiff and Vale University Health Board ("the Health Board") that:

a) there was a failure to properly undertake a procedure which set back F's recovery
b) the Health Board did not intervene early enough when concerns were raised about F's mobility
c) Mrs E was not adequately informed about the risks of surgery to her son.

The complaint was not upheld. The investigation found that the appropriate procedure was followed but that unfortunately, it did not go to plan which resulted in additional measures to support F's recovery. There were minor delays in undertaking tests when concerns about F's mobility were raised. However, earlier intervention would not have altered the outcome. Mrs E was provided adequate information about the risks of surgery, in line with appropriate guidance. Sadly the complications which arose in F's case could not have been predicted.

**Aneurin Bevan University Health Board – Clinical treatment in hospitals**
**Case Reference 201405977 – Report issued in November 2015**
Mr A complained that no home care or nurse visits were carried out to support his son, Mr B, from the point that Aneurin Bevan University Health Board ("the Health Board") took over his home oxygen service from a neighbouring health board in April 2013 until a visit undertaken by two nurses on 18 September 2014, immediately prior to his final hospital admission. Mr B sadly died on 23 September.

Mr A also had concerns about the adequacy of the treatment Mr B received during this final admission and about various communication issues, including a failure to inform Mr B/his family of his diagnosis and its seriousness, as well as a failure to discuss with either Mr B or his wife, Mrs B, the decision to complete a Do Not Attempt Resuscitation form.

The Ombudsman found that the Health Board's position – that it had treated and communicated with Mr B appropriately – was largely supported by relevant entries in Mr B's records. The Adviser said that the treatment Mr B received was appropriate and that his sudden deterioration could not reasonably have been foreseen or prevented. The Ombudsman concluded that Mr B's sad death did not result from any shortcomings in his care and did not, therefore, uphold the complaint.

**Abertawe Bro Morgannwg University Health Board – clinical treatment in hospital**
**Case reference 201408174 - report issued in December 2015**
Mrs A complained to the Ombudsman that Abertawe Bro Morgannwg University Health Board ("the Health Board") had failed to manage her late husband's care after he had experienced breathing difficulties and chest pain and was referred to hospital. Mrs A was also concerned that even though her husband had been under the care of the respiratory team for several years for his breathlessness, the presence of a blocked coronary artery was not identified earlier.

The Ombudsman found, based on the professional advice he received, that the management of Mr A's treatment and the actions taken by his clinicians had been appropriate given his presentation. The Ombudsman's advice also indicated that it was reasonable for Mr A's doctors not to have identified his blocked coronary artery earlier. The
Ombudsman arrived at this view because Mr A's previous medical history, his ongoing presentation and the outcome of investigations undertaken, suggested an alternative cause for his breathlessness.

Accordingly the Ombudsman did not uphold the complaint.

**Cardiff and Vale University Health Board and a GP Surgery in Cardiff and Vale University Health Board's area – clinical treatment outside hospital**
**Case reference 201408950/201408954 - report issued in December 2015**
Mrs M complained about the standard of care that her son, Mr A, received from his GPs and Cardiff and Vale University Health Board ("the Health Board") after he was discharged from hospital. Mrs

M said that her son was ill enough to warrant being sectioned under the Mental Health Act or admitted as a voluntary patient to the psychiatric unit.

The Ombudsman's investigations concluded the care provided by the GPs was reasonable and appropriate and did not uphold this aspect of Mrs M's complaint.

In relation to the Health Board, the Ombudsman was critical that when Mr A started to voice concerns about his suicidal thoughts in October, his care was not escalated to a psychiatrist. This resulted in a failure to undertake a meaningful and comprehensive assessment (including a suicide risk assessment) and consequently represented a lost opportunity to properly evaluate Mr A's mental health and formulate any diagnosis /future treatment plan. Mrs M's complaint was upheld.

The Ombudsman recommended that the Health Board should apologise in writing to Mrs M and make a financial redress payment of £750 for the distress caused by the failings. The Health Board was also asked to remind its clinical staff the need to conduct suicide risk assessments. It was also asked to draw up a policy to ensure that staff carry out a mental state examination when a patient expresses suicidal ideas.

## Quick fixes & voluntary settlements

**Cardiff and Vale University Health Board - Patient list issues**
**Case reference 201503700 - Report issued in October 2015**
Mrs A contacted the Ombudsman to complain that she had not received a formal response to her complaint. Mrs A complained to Cardiff and Vale University Health Board ("the Health Board") in May 2015.

The Ombudsman contacted the Health Board to find out the reasons for the delay. The Health Board apologised for the delay in sending a formal response to Mrs A. The Health Board agreed to write to Mrs A within the next ten working days.

**Aneurin Bevan University Health Board - Health - Clinical treatment in hospital**
**Case reference 201501342 - Report issued in October 2015**
Ms S raised a complaint regarding the delay caused by Aneurin Bevan University Health Board ("the Health Board") in responding to her complaint, which was originally made in July 2013. Ms S continued to seek an update about her complaint; however, she complained that her most recent correspondence sent in July 2014, had received no response.

The Ombudsman noted that there was some uncertainty about how the complaint was being considered, and that Ms S had experienced significant delays as a result. Following discussions with the Health Board it agreed to take the following action:

a) to continue its consideration of Ms S's complaint under the Putting Things Right Regulations and to take steps to jointly instruct an expert, to advice on the issue of causation
b) to make a payment to Ms S in the sum of £500 for the poor management of her complaint

c) the commencement date of the suspension of the limitation period shall be the date the concern was first received by the Health Board in accordance with Putting Things Right Guidance and that it will confirm the same to Miss S.

**Aneurin Bevan University Health Board – Clinical treatment inside hospital**
**Case Reference 201502093 – Report issued in October 2015**

Mr A complained about a delay in diagnosis of a deep sited infection following a total knee replacement. The infection resulted in revision surgery.

Aneurin Bevan University Health Board ("the Health Board") undertook a clinical review of the case. It acknowledged that there had been failings in the continuity of care which had led to a delay in diagnosing the infection but said that the final treatment would have remained the same. It also accepted that there had been failings in the complaint handling. The Health Board agreed to:

a) offer a full apology for the delay and provide an explanation for where things may have gone wrong and advise him what it has done to reduce the risk of this issue happening again

b) offer a full apology for the failings identified in the complaint handling

c) make a redress payment of £500 to Mr A in recognition of the failings identified

d) discuss the case at a clinical audit meeting and discuss the case with the clinical staff involved with Mr A's care and the complaint handling staff who dealt with Mr A's complaint.

**Powys Teaching Health Board – Continuing Care**
**Case Reference 201501195 – Report issued October 2015**

Mr A's Solicitors complained about Powys Teaching Health Board's ("the Health Board") decision to limit the period which it was willing to undertake a retrospective Continuing NHS Healthcare ("CHC") review in respect of Mr A's mother. Mr A's retrospective CHC request, which dated back to 2010, was made after the Welsh Government's cut off date of 31 July 2014 for such applications. Mr A's mother, a self funded resident in a nursing home, had been eligible for NHS funded nursing care since January 2010. The Health Board had previously acknowledged that it had not carried out annual needs assessments on Mr A's mother in 2012 and 2013.

The Ombudsman was not persuaded that the reasons that the Health Board had given for not following national guidance on assessments were sufficient. Had annual assessments taken place, Mr A would have had an opportunity to request a retrospective CHC review dating back to 2010. At that stage the Welsh Government's restrictions on such application had not been introduced.

The Health Board agreed to the Ombudsman's settlement proposal, which was an extension of the period that Mr A could request a retrospective CHC review to 8 December 2010.

**Hendy Gwyn Dental Centre (Integrated Dental Holdings Ltd- IDH) – Clinical treatment outside hospital**
**Case Reference 201501743 - Report issued October 2015**
Mr B complained about the care and treatment he received when he attended Hendy Gwyn Dental Centre ("the Dental Centre") on two occasions with a loose fitting crown. Mr B complained that the work was 'poorly undertaken' and that one of the dentists he saw was rude and abrupt in his manner.

Mr B complained that within two weeks the crown had loosened and became unstable and that, as a result, he felt obliged to seek dental treatment from his former (private) dentist, thereby incurring dental charges.

The Dental Centre / IDH acknowledged that there were shortcomings in the way that it dealt with Mr B's complaint and in the way that it was not properly explained or recorded that the work undertaken was temporary. The Dental Centre also acknowledged that it should not have charged Mr B for one of his appointments. The dentist apologised if Mr B perceived him as rude or aggressive.

The Dental Centre / IDH and the Ombudsman considered that rather than progressing the investigation, the complaint could be resolved by way of an agreed settlement. Mr B was content with this approach.

The following settlement terms were agreed:

a) that Mr B receives a letter of apology for the identified shortcomings
b) that the Dental Centre / IDH provides Mr B with a redress payment of £300
c) that the Dental Centre takes steps to improve its complaint handling.

**Cwm Taf University Health Board – Continuing Care**
**Case Reference 201403060 - Report issued October 2015**
Mrs B said that Cwm Taf University Health Board ("the Health Board") had not addressed three appeals, which she had made for NHS funded continuing care ("NHSFCC") via her solicitor. Mrs B had made these appeals on behalf of her aunt, Miss A. She also said, at the time of her complaint to the Ombudsman, that the Health Board had not determined her retrospective claim for NHSFCC in respect of Miss A. She complained that it was taking too long to do this.

The Ombudsman found that the Health Board had not dealt with Mrs B's appeals, as required. He also noted that it took approximately six years and six months to determine her retrospective claim. He concluded that the Health Board's response to Mrs B's appeals and her retrospective claim was exceptionally poor. He upheld Mrs B's complaint as a result. The Ombudsmanrecommended that the Health Board should:

a) write to Miss A, via Mrs B, to apologise for the failings identified and to outline the "lessons" that it has learnt because of Mrs B's experience

b) write to Mrs B to apologise for the failings identified and to outline the "lessons" that it has learnt because of her experience

c) pay Miss A, via Mrs B, a nominal sum of £500, in recognition of the cumulative impact that the significant review failings identified might have had and/or could have, upon her

d) pay Mrs B a nominal sum of £250, in recognition of the inconvenience and uncertainty that she has experienced because of the significant review failings identified

e) give him documentary evidence, which demonstrates that the significant review failings identified will not be repeated.

The Health Board agreed to implement these recommendations.

**Betsi Cadwaladr University Health Board – Clinical treatment in hospital**
**Case Reference 201403937 - Report issued October 2015**

Mrs Y complained about the way in which Betsi Cadwaladr University Health Board ("the Health Board") managed her total right knee replacement operation ("the Right TKR Operation") and associated symptoms. She said that the knee implant, which the Orthopaedic Surgeon ("the Surgeon") used, was the "wrong size." She reported that the Surgeon also "refused" to "straighten" her right leg during this procedure. She said that he did not investigate the cause of the pain in her right hip. She indicated that she had suffered unnecessarily because of these alleged failings. She also complained that the Health Board did not consider her complaint, against the Surgeon, properly.

The Ombudsman did not uphold the clinical elements of Mrs Y's complaint. However, he found that the Health Board's response to her complaint had been deficient. He partly upheld the complaint handling aspect of Mrs Y's complaint as a result. He recommended that the Health Board should:

a) write to Mrs Y to acknowledge, and apologise for, its failure to obtain a second opinion from an independent clinician
b) share his investigation report with staff members who are involved in the investigation of complaints and highlight the importance of obtaining a second opinion.

The Health Board agreed to implement these recommendations.

**Hywel Dda University Health Board – Clinical treatment in hospital**
**Case Reference 201500635- Report issued October 2015**

Mrs X complained that her late mother, Mrs Y, should not have been discharged from Withybush hospital's A&E department at 03.00am on 18 January 2014. She said that the junior doctor who treated her mother failed to diagnose her dissecting aortic aneurysm. She also said that had clinicians decided to admit her mother, there was a period of some nine hours where more thorough tests could have been done and treatment provided.

The Ombudsman's clinical adviser said that Mrs Y's clinical presentation was such that she should have been admitted for further investigations. With admission, there would have been an opportunity for assessment by a more experienced doctor who would have been able to reach the correct diagnosis. However, the time period in question was probably insufficient for Mrs Y to have been able to have received the correct treatment. Mortality rates for those with dissecting aneurysms are also high. It was, sadly, very likely that Mrs Y would have died even had she been admitted.

Hywel Dda Health Board accepted that Mrs Y should have been admitted for further investigation. In recognition of that it said that it would:

a) offer Mrs X a payment of £2,250.
b) update its junior doctor's handbook with respect to advice for A&E Staff to include a number of principles regarding the discharge of patients with suspected coronary conditions, particularly that junior doctors should refer such cases to more senior colleagues and undertake further investigations prior to discharge.

The Ombudsman considered that the action the Health Board said it would take was reasonable. He therefore considered the complaint to be settled.

**Cardiff and Vale University LHB - Clinical treatment in hospital**
**Case reference 201500005 - Report Issued in November 2015**
Mrs W complained about the care provided to her late sister at University Hospital Llandough. Mrs W's concerns relate to an incident where her sister slipped from a chair and the ward's actions in contacting the Care Home where her sister had been resident with a view to discharging her before she was physically fit.

Mrs W complained to Cardiff and Vale University LHB ("the Health Board") and a response was provided in October 2014. Having considered the response provided the Ombudsman felt that the Health Board had not fully addressed each of the issues raised by Mrs W. On this basis the Health Board was asked to provide Mrs W with a further written response dealing fully with the questions posed.

The Health Board agreed to provide Mrs W with a further written response dealing with all outstanding issues within 10 working days.

**Cwm Taf University Health Board - Clinical treatment in hospital**
**Case reference 201503473 – Report issued in November 2015**
Mr T complained to the Ombudsman about the length of time it was taking Cwm Taf University Health Board ("the Health Board") to investigate concerns about a relative's care and treatment in hospital. Mr T was unhappy with the complaints handling process.

The Health Board acknowledged the delays in providing Mr T with a full response. In the interim the has Health Board agreed to apologise in writing to Mr T and offer a redress payment of £250 in

recognition of the delay.

**Hywel Dda University Health Board - Clinical treatment in hospital**
**Case reference 201504216 – Report issued in November 2015**
Miss S complained about the treatment that her late mother received during her inpatient stay at Bronglais General Hospital in January 2015. Miss S said that Hywel Dda University Health Board ("the Health Board") had carried out an investigation into her complaint but that its response had failed to address a number of issues, or in part did not refer to her mother. Miss S complained that she was unhappy with the Health Board's response.

On receipt of the complaint, the Ombudsman noted that Miss S had outlined in her letter to him the issues which in her view had not been addressed by the Health Board. The Ombudsman considered that it would be beneficial for Miss S to receive a further response from the Health Board.
Having discussed this matter with the Health Board it agreed to provide a further written response by 15 December 2015.

**IDH Group Limited - Clinical treatment outside hospital**
**Case reference 201504010 – Report issued in November 2015**
Mrs C complained that she had been required to attend several appointments at the dental practice in order to resolve an issue of a badly fitting denture.

The Ombudsman found that there had been an excess of appointments attended by Mrs C as a result of poor fitting dentures being made. He recommended that the practice:
a) write a letter of apology to Mrs C, and
b) offer a payment of £68 as a goodwill gesture for the excess travelling costs incurred by Mrs C.

The practice agreed to do this within twenty working days .

**Cwm Taf University Health Board - Clinical treatment in hospital**
**Case reference 201502712 – Report issued in November 2015**
Mr W complained that he submitted a complaint to Cwm Taf University Health Board ("the Health Board") on behalf of his Client on 7 October 2014, concerning the care and treatment provided to his Client's late mother, whilst a patient at Prince Charles Hospital. A response dated 5 February 2015 was received from the Health Board but there has since been delays in addressing the outstanding issues. At the time of bringing this complaint to the Ombudsman Mr W's Client had still not received a further response.

On receipt of this complaint, the Ombudsman contacted the Health Board which agreed to the following:

a) to write to Mr W and his Client with an update by 27 November 2015
b) to apologise for the delay in providing a final response and explain what has gone wrong by 27 November 2015

c) to make a token payment of redress as recognition for the additional distress by 27 November 2015.

The Ombudsman was satisfied that the actions the Health Board said it would take were reasonable and would resolve the complaint. Accordingly, he considered the matter to be settled. However, Mr W was advised to come back to the Ombudsman if the action promised by the Health Board did not materialise, by 30 November 2015 or, was unsatisfactory.

**Hywel Dda University Health Board - Complaints Handling - Health**
**Case reference 201503940 – Report issued in November 2015**

Mrs P complained that at the time of submitting a complaint to the Ombudsman she had not received a response from the Health Board in relation to a complaint she submitted to it in March 2014 following dissatisfaction with treatment received in hospital in February 2014.

After receiving this complaint the Ombudsman contacted the Health Board to make enquiries and discuss Mrs P's concerns. He was told that due to the nature of the concerns there had been a delay in allocating the complaint to the appropriate officer but was also assured that it was receiving attention, and comments from a Consultant were awaited.

The Health Board agreed to the following:
a) pay a minimum of £250 to Mrs P in recognition of the Health Board's failure to deal with her complaint in an appropriate time, by 20 November 2015
b) write to Mrs P apologising for the extreme delay, by 20 November 2015
c) provide an explanation for the delay, by 20 November 2015
d) give an indication of the date that the response will be sent, which must be before the end of 2015.

The Ombudsman was satisfied that the action which the Health Board said it would take was reasonable and would resolve this complaint. Accordingly, he considered the matter to be settled. However, Mrs P was advised to come back to the Ombudsman if the actions promised by the Health Board did not materialise or were unsatisfactory.

**Betsi Cadwaladr University Health Board – Clinical treatment in hospital**
**Case Reference 201503451 – Report issued in November 2015**

Mr X complained about the Health Board's delay in responding to his complaint under Regulation 33 of the Putting Things Right Regulations. He said that the Health Board had taken over a year to respond and had not been providing meaningful updates to his solicitor.

The Health Board said that its legal and risk department had Mr X's file and was dealing with it as a priority. It said that a response should be issued shortly. The Health Board apologised for the delay and offered Mr X a payment of £500 in recognition of the delay and the lack of meaningful updates.

The Ombudsman agreed that the Health Board's actions amounted to a reasonable settlement of the complaint.

**Hywel Dda University Health Board – Clinical treatment in hospital**
**Case Number 201408844**

Mr X complained about the lack of treatment / support by the Community Mental Health Team (CMHT) between June and August 2014.

Hywel Dda University Health Board ("the Health Board") acknowledged that there were shortcomings in Mr X's care, in particular, that there was inadequate follow up by the CMHT following discharge (after a short period as a voluntary inpatient). Mr X was subsequently detained under section two weeks later.

The Health Board and the Ombudsman considered that the complaint could be resolved by way of an agreed settlement which included that the Health Board should:
a) apologise to Mr X and provide him with a redress payment of £500
b) invite him and his advocate to a meeting to discuss the shortcomings in his care
c) remind staff about the importance of record keeping and about the current system on discharge of patients not active to CMHT on admission.

**Hywel Dda University Health Board – Continuing NHS Healthcare**
**Case reference 201501440 - report issued in December 2015**

Mr D complained about Hywel Dda University Health Board's ("the Health Board") handling of a claim for NHS funded continuing care in respect of his father, Mr E. The Ombudsman found maladministration in the consideration of the claim by an independent review panel (IRP). In particular, he concluded that the IRP appeared to have misinterpreted some of the domains in the decision support tool, gave too much weight to the care setting and non-involvement of particular professionals and that the notes of the IRP did not demonstrate a robust consideration of the four key indicators or the totality of Mr E's needs.

In view of the concerns identified by the investigation, the Ombudsman invited the Health Board to settle the complaint by arranging for the claim to be reheard by a fresh IRP. The Health Board agreed, and the Ombudsman's investigation was discontinued on that basis.

**Cwm Taf University Health Board - Clinical treatment in hospital**
**Case reference 201504123 - report issued in December 2015**

Mrs J's complaint related to her diagnosis and treatment for Deep Vein Thrombosis ("DVT") which has been recurrent since 2013. Mrs J explained that in April 2015, she attended A&E for treatment of her chronic pain, but was concerned, following no diagnosis of DVT about where the blood clot has gone.

The Ombudsman was satisfied that Cwm Taf University Health Board's ("the Health Board") response to Mrs J's concerns was reasonable, however, he noted that a greater explanation could have been provided by the Health Board to alleviate Mrs J's remaining concerns. The Health Board

agreed to the the Ombudsman's recommendation that it should contact Mrs J directly to arrange a suitable date to meet and provide further information about her remaining concerns.

**Betsi Cadwaladr University Health Board – Clinical treatment in hospital**
**Case reference 201504721 - report issued in December 2015**
Ms M complained about certain nursing staff involved in her care after she underwent surgery. In particular, she complained about personal comments made, which upset her, and she alleged that a nurse had threatened her/made comments she found threatening.

In responding to Ms M's complaint, four months after it was made, Betsi Cadwaladr University Health Board ("the Health Board") said it had spoken with identified staff. It apologised if Ms M had been upset by some comments which, it was said, had been intended as a compliment when made to her by the nurse concerned. Its letter, however, did not address the allegation of a threat made to Ms M, nor apologise for its delay in responding to her.
Taking into account that the Ombudsman would face difficulty in investigating accounts of verbal exchanges, or individual perception, he recommended the following as a resolution, which the Health Board agreed to implement. The Health Board should:

a) apologise for its delay in responding to Ms M's original complaint
b) within that letter respond to the outstanding complaint issue its original letter had failed to deal with.

**Hywel Dda University Health Board - Clinical treatment in hospital**
**Case reference 201502635 - report issued in December 2015**
Mrs O complained to Hywel Dda University Health Board ("the Health Board") that her mother sustained a fall whilst under the care of nursing staff at Bronglais General Hospital. The Health Board provided its response but Mrs O remained dissatisfied and sent a further letter on 7 August 2015. Mrs O complained to the Ombudsman that the Health Board had failed to respond to her letter and it had not considered offering compensation for her mother's injuries.

On receipt of the complaint, the Ombudsman contacted the Health Board to discuss Mrs O's concerns. The Health Board explained that it had carried out a further review of the complaint and considered that there may be cause to consider a 'qualifying liability' in the case.

The Health Board agreed to finalise and inform Mrs O of its decision.

**Cardiff and Vale University LHB - Clinical treatment in hospital**
**Case reference 201503799 - report issued in December 2015**
Mr A complained that, following an accident at work, he was required to travel home alone on public transport when he was discharged from the Emergency Unit of the University Hospital of Wales and that a scan was not carried out before he was discharged. Mr A was required to return to the hospital within a few hours, at which point a scan was carried out which revealed that he had sustained a fractured skull. Mr A remained concerned about what may have happened had he not

returned to the hospital and was unhappy with the action taken by Cardiff and Vale University LHB ("the Health Board") in response to his complaint.

Having considered the information provided on behalf of the complainant, the Ombudsman approached the Health Board on the basis that it appeared that its internal investigation had identified some serious service failings and a redress payment to reflect the injustice and time and trouble caused to Mr A seemed appropriate. The Health Board agreed to settle the complaint by making a payment of £250 to Mr A. It also agreed to provide supporting evidence of the action taken to comply with the recommendations of its internal investigation.

The Ombudsman concluded that the action which the Health Board said it would take was reasonable to settle the complaint and closed the file on this basis.

## Complaint-handling

## Quick fixes & voluntary settlements

**Betsi Cadwaladr University Health Board - Other**
**Case reference 201503027 - Report issued in October 2015**
Ms A complained that Betsi Cadwaladr University Health Board ("the Health Board") had failed to provide her with a full response in regards to a complaint submitted in April 2013.

The Ombudsman contacted the Health Board and in turn it explained its reasons for part of the delay. However, the Ombudsman was of the view that there has been an unreasonable delay in responding to Ms A or her advocate, and a failure to provide them with regular meaningful updates throughout the process.

It was agreed that the Health Board would:

a) provide Ms A with an apology in writing for its complaint handling and failure to provide meaningful updates
b) offer Ms A a payment of £700 for the time in trouble in bringing her complaint to this office.

**Betsi Cadwaladr University Health Board - Health**
**Case reference 201503952 - Report issued in October 2015**
An advocate from the Community Health Council ("CHC") complained that her client had been waiting for a response to her concerns from the Health Board for many months, and that all efforts undertaken by the CHC to expedite had failed to generate a response. The delay was causing the client further distress.

The Ombudsman wrote formally to the Health Board expressing concerns at the significant delay, imposing a final deadline (of 5 working days) for a response. He also requested an explanation for the delays, and that apologies be tendered to the CHC and their client. The Health Board provided a detailed response within the deadline as requested. It also issued formal apologies to both parties, providing copies of all letters to the Ombudsman. The complaint as made to the Ombudsman was therefore resolved on this basis.

**Cwm Taf University Health Board - Complaints Handling -Health**
**Case reference 201503874 – Report issued in November 2015**
Mr G complained about the length of time it was taking Cwm Taf University Health Board ("the Health Board") to conclude his complaint which he originally made back in March 2013.

On receipt of Mr G's complaint, the Ombudsman contacted the Health Board for further information relating to the complaint. He also recommended that a payment and explanation should be made to Mr G due to the length of time it was taking the Health Board to conclude his complaint.

The Health Board responded and agreed that a payment and full explanation would be considered and included in its final response to Mr G. The Health Board informed the Ombudsman that the

final response was likely to be sent to Mr G within four weeks.

**Betsi Cadwaladr University Health Board - Health**
**Case Reference 201502561 – Report issued in November 2015**
Mrs X complained about a delay by Betsi Cadwaladr University Health Board ("the Health Board") in providing her with a response to her complaint which she submitted via her CHC advocate on 27 May 2014.

The Health Board failed to respond to Mrs X within the timeframe specified by the "Putting Things Right" complaints procedure. In addition the Health Board failed to provide Mrs X or her advocate with regular updates.

The Health Board agreed to:

a) provide Mrs X and her advocate with an apology and full reasons for the delay in responding to the complaint
b) provide Mrs X with a payment of £700 in recognition of the time and trouble in having to bring her complaint to the Ombudsman, the Health Board's failure to provide meaningful updates to Mrs X and her advocate and the delay in providing a response
c) remind the clinicians involved of the importance of providing prompt replies to requests for comments on complaints
d) make arrangements to escalate late clinical responses to the Medical Director or the Nursing Director as appropriate; and
e) remind staff involved of the importance of systemic and orderly record keeping.

**Cwm Taf University Health Board - Complaints Handling - Health**
**Case reference 201501809 – Report issued in November 2015**
Mrs A complained about unreasonable delay by Cwm Taf University Health Board ("the Health Board") in providing a meeting to discuss concerns about her mother's treatment and care. Mrs A asked the Ombudsman to intervene on her behalf to bring the meeting about.

On receipt of the complaint, the Ombudsman contacted the Health Board and it arranged a mutually convenient meeting with Mrs A. At the meeting, the Health Board also agreed to undertake an independent review of her mother's care.

**Hywel Dda University Health Board - Complaints Handling – Health**
**Case reference 201501305 – Report issued in November 2015**
Mrs H complained about the care and treatment that her mother received at Glangwili General Hospital ("the hospital"). Mrs H 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 H's 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 H complained to the Ombudsman that the Health Board failed to provide its response to her complaint.

Following consideration of the complaint, the Ombudsman contacted the Health Board to discuss Mrs H's concerns. The Ombudsman 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.

**Betsi Cadwaladr University Health Board – Complaints Handling**
**Case reference 201504277 – Report issued in December 2015**
Ms X complained that she had not received a response to a complaint she made to the Health Board in April 2014.

On receipt of the complaint, the Ombudsman contacted the Health Board for information. The Ombudsman asked the Health Board to provide Ms X with a meaningful update, a full apology and a cheque for £300 in recognition of the delay. The Health Board agreed to the proposal.

## Education

## Upheld

**Isle of Anglesey County Council Education - Special Educational Needs (SEN)**
**Case Reference 201408779- Report issued in October 2015**
Mrs A complained that the Isle of Anglesey Council as Local Education Authority ("the LEA") did not take appropriate action to ensure that the special educational needs of her two sons (B and C) were met. She also complained that the LEA did not arrange to reassess C's special educational needs in a timely manner.

The Ombudsman did not uphold the complaint regarding B's special educational needs. However, the Ombudsman found that, from September 2013, when C was not attending school due to severe anxiety, the LEA had a duty to ensure that he received suitable educational provision, taking into account his special educational needs. Despite attempts to put in place educational provision, the LEA did not consider alternative provision when the initial plan for small group provision failed.

The Ombudsman also found that when a decision was made to reassess C's special educational needs, the LEA did not carry out this process in accordance with relevant regulations.

The Ombudsman upheld the majority of Mrs A's complaints. He made a number of recommendations including:

a) an apology
b) financial redress of £250 in recognition of the time and trouble in pursing her complaint
c) consideration of further training for staff
d) an assessment of the educational proposals put forward for C to determine whether there was any shortfall in educational provision
e) review procedures to ensure compliance with legislation / guidance.

The LEA agreed to all the recommendations.

## Quick fixes & voluntary settlements

**Cardiff Council - Other**
**Case reference 201502924 - report issued in December 2015**
Mr & Mrs B complained that the Education Welfare Service of the Council failed to follow paragraph 4 of its Code of Conduct in issuing Fixed Penalty Notices concerning their children's absence from school. When informed that the Ombudsman was investigating the complaint, the Council agreed to cancel the Fixed Penalty Notices, and to review its Code of Conduct. The Ombudsman's therefore considered this matter to be resolved.

**Ceredigion County Council – Special Educational Needs**
**Case Reference 201504254 – report issued in December 2015**

Mr A's son ("X"), aged 16, had a Statement of Special Education Needs (SEN). Mr A complained that Ceredigion County Council ("the Council") had called him to a meeting "out of the blue" to inform him that the Statement of SEN had lapsed. Therefore, it said that the Council would no longer continue to fund X's provision. The Council did not issue a written decision, being of the view it was not required to under the relevant Code of Practice, thereby denying Mr A any avenue of appeal to the relevant Tribunal (SENTW).

Whilst not for him to interpret a statutory Code of Practice, following consideration and representations from the Ombudsman, the Council agreed to review its position. It also agreed to continue with X's provision under the Statement until it had concluded an Annual Review. It would then issue a decision in writing to Mr A with reasons if it considered the Statement should cease. This would afford Mr A the right to appeal to the SENTW, if he was minded to do so. The Ombudsman considered that this was a reasonable resolution of the complaint.

## Environment & Environmental Health

## Upheld

**Flintshire County Council - Refuse collection. recycling and waste disposal**
**Case Reference 201500139 – Report issued in November 2015**
Ms A complained that she and her mother had experienced significant problems with the Council's assisted refuse collection service since July 2013. Ms A's mother is disabled and Ms A has her own health problems which mean that they are unable to move the bins themselves. Ms A said that on a number of occasions the bins were not put back in the right place, the lids were left open causing them to fill with rainwater, were not emptied at all, or the garden gate was not closed after the collection.

The Ombudsman found that the number of errors in the assisted collections in this case was unacceptably high, particularly given the difficulties Ms A and her mother faced if the collections were not carried out properly. He upheld the complaint and recommended that the Council apologise and pay Ms A £350 to recognise the time, trouble and worry she and her mother had been caused. The Ombudsman noted that the training and technological measures the Council had now put in place should hopefully reduce the risk of significant problems happening again.

## Quick fixes and Voluntary settlements

**Powys County Council – Environment and Environmental Health**
**Case Reference 201504476 – Report issued in November 2015**
In Mr M's most recent letter to the Ombudsman he complained that Powys County Council ("the Council") had failed to provide him with a Stage 2 response in a timely manner. Mr M said that he was still awaiting a Stage 2 response. Mr M also stated that the Council was unable to expedite any enforcement on the issues he raises.

However, as the Ombudsman understands, the Council did respond to Mr M's complaint under Stage 2 of the Complaints Process and its response was sent to him via email on 30 October 2015 at 14:52pm. The email was sent to his email address given on the complaint form. Mr M states he did not receive a copy of this. The Ombudsman therefore sent a copy of the email and the noise nuisance report for his information.

**Cardiff Council - Environment and Environmental Health**
**Case Reference 201504103 – Report issued in November 2015**
Mr J complained that, in September, during a normal waste collection, Cardiff Council ("the Council") removed his black bin. Mr J said that he contacted the Council on numerous occasions requesting that it replaced his black bin.

On receipt of this complaint, the Ombudsman contacted the Council to make enquiries with regard to when Mr J could expect to receive a black bin and, after discussions with the relevant department, he was told that a delivery of a black bin was arranged. Mr J subsequently contacted

the Ombudsman to advise that he had now received this.

The Ombudsman was satisfied that the action which the Council had taken was reasonable and therefore the complaint was resolved.

# Housing

## Quick fixes and Voluntary settlements

**Derwen Cymru – Other**
**Case reference 201503184 - Report issued in October 2015**
Mr M complained that Derwen Cymru were not providing maintenance to street lighting, grass verges and a surface water soak away around his home.

The investigation found that Derwen Cymru was in ongoing discussions with the property management company to resolve the issues complained of. The Ombudsman recommended that Derwen Cymru shouild:

a) write a letter to Mr M outlining the current situation within 20 working days.
b) include an action plan in the letter of its proposed action and timescales for completion.

**Wrexham County Borough Council - Neighbour disputes/anti social behaviour**
**Case Reference 201501336 - Report issued October 2015**
Mrs X complained that Wrexham County Borough Council ("the Council") failed to resolve her anti-social behaviour complaint. Mrs X also raised concerns that her housing application had been incorrectly categorised by the Council.

The investigation found that the Council failed to address part of Mrs X's anti-social behaviour complaint. The Council also failed to fully consider the documentation provided in support of Mrs X's housing application.

During the course of the investigation, the Council offered Mrs X alternative property, which she accepted in settlement of the complaint.

The Council also agreed to the following, should the offer fall through:

a) re-consider and provide Mrs X with a further response to her complaint
b) re-consider Mrs X's housing application; and
c) provide Mrs X with a single point of contact to assist her with the mutual house exchange process.

**Ceredigion County Council - Homeless person issues**
**Case Reference 201403291- Report issued October 2015**
Ms A suggested that Ceredigion County Council ("the Council") had not managed her housing applications correctly. She specifically complained that it had failed to act appropriately after it had given her homelessness points. She also said that it had not communicated effectively, with her, about her housing situation.

The Ombudsman did not identify any critical failings in terms of the way in which the Council's

Housing Service had dealt with Ms A's housing applications. He also found that the Council's Housing Service had acted appropriately after it had determined that Ms A was homeless. However, he concluded that the Council's Environmental Health Service ("the EHS") had not responded to two referrals, which it had received from the Council's Housing Service, satisfactorily. He partly upheld Ms A's complaint as a result. He recommended that the Council should:

a) write to Ms A to apologise for the EHS failings identified
b) pay Ms A a nominal sum of £100 in recognition of the fact that some of the housing difficulties, which she experienced, might have been ameliorated and/or eliminated if the EHS failings identified had not occurred
c) review the way in which its EHS responds to complaints with a view to preventing a recurrence of the failings identified.

The Council agreed to implement these recommendations.

**Cymdeithas Tai Cantref – Applications, allocations, transfer and exchanges**
**Case Reference 201406051- Report issued October 2015**
Ms A indicated that Cymdeithas Tai Cantref ("Cantref") had not taken its decision to permanently assign a property ("the Property"), which it had offered to her, to another person ("Ms G"), properly. She also suggested that its management of this assignment compromised her housing situation. She complained that Cantref had not involved her in its decisions about the Property or kept her informed.

The Ombudsman did not determine that Cantref's decision to permanently assign the Property, to Ms G, was unreasonable, or that its management of this assignment jeopardised Ms A's housing position. Nor did he consider that Cantref should have involved Ms A in its assignment decision. However, he was not satisfied, due to the inadequacy of Cantref's records, that Cantref took this decision correctly. He also considered that Cantref's communication, with Ms A, was deficient. He partly upheld Ms A's complaint as a result. He recommended that Cantref should:

a) write to Ms A to apologise for the failings identified
b) confirm, when writing to Ms A, that the relevant Council did not sanction its decision to permanently assign the Property to Ms G
c) arrange record keeping training for staff members with a view to preventing a recurrence of the failings identified
d) review its existing record keeping system and take any action required to ensure that its records are sufficiently robust and, where possible, contemporaneous.

Cantref agreed to implement these recommendations.

**Clwyd Alyn Housing Association Ltd - Housing**
**Case reference 201503886 – Report issued in November 2015**
Mr B was unhappy about the delay in processing his application for a transfer to more suitable

accommodation. Clwyd Alyn Housing Association Ltd ("the Housing Association") had previously offered him a payment in recognition of this.

The Ombudsman confirmed that the delay was in excess of the Housing Association's relevant policy. The Housing Association therefore agreed to increase the payment offered to Mr B to £75.

It had also previously confirmed that it would date Mr B's application from the day it was received to ensure he was not disadvantaged further.

**Linc-Cymru Housing Association – Housing**
**Case reference 201504044 - Report issued in November 2015**
Mr J complained that Linc-Cymru Housing Association ("the Housing Association") failed to repair his hot water and bathing facilities. Mr J says he first reported the incident on 11 September 2015. Mr J also says a number of contractors visited his property to try and repair the faulty facilities; however, they were unsuccessful in doing so. A new cylinder has now been installed and the hot water is working.

Mr J also stated that he had raised these concerns in a complaint to the Housing Association and was still awaiting a response.

On receiving Mr J's complaint, the Ombudsman contacted the Housing Association for further information and requested copies all documentation relating to his complaint.

The Housing Association responded by explaining that an officer had been to visit Mr J at his property to discuss the repairs and complaint. The Housing Association also informed the Ombudsman that a payment of £120 was offered to reimburse Mr J for any expenses he incurred whilst the repairs were underway. Mr J accepted this offer.

**Cardiff Council - Repairs and maintenance**
**Case reference 201503564 – Report issued in November 2015**
Mr S complaint related to several aspects surrounding a visit by an operative of Cardiff Council ("the Council") to carry out repair work. Mr S had complained to the Council and it responded to him apologising for any distressed caused and informing him that the operative has been spoken to and reminded of the correct procedures.

After considering the contents of the complaint, the Ombudsman asked the Council to offer Mr S a time and trouble payment for any inconvenience caused. The Council agreed to offer a payment of £25.

**Cardiff Council - Repairs and maintenance (inc dampness/improvements and alterations e.g. central heating. double glazing)**
**Case Reference 201503614 – Report issued in November 2015**
Mr and Mrs T complained to the Ombudsman about the lack of communication and the poor

service received from Cardiff Council ("the Council"). After considering the information provided it appeared that the Council had not undertaken a detailed investigation of the concerns raised by Mr and Mrs T, or provided an explanation of the difficulties it had been experiencing.

It was agreed with the Council they would:
a) provide a further explanation to the concerns raised
b) offer a time and trouble payment of £50.

**Cardiff Council – Housing**
**Case Reference 201503780 – Report issued in December 2015**
Miss C's complaint related to her request to move properties and downsize. She stated that the Council did not take into consideration her son's disability when it offered her new properties. This resulted in Miss C having to refuse a number of properties due to the lack of suitability, causing the Council to suspend her application for re-housing for twelve months.

On receipt of the complaint, the Ombudsman contacted the Council for further information and an update. The Ombudsman was informed that the review request had been completed by the Council, and that it would make Miss C one final offer.

**Cardiff Community Housing Association Ltd - Repairs and maintenance (inc dampness/ improvements and alterations e.g. central heating. double glazing)**
**Case reference 201504282 – report issued in December 2015**
The complainant Mr F complained that Cardiff Community Housing Association Ltd ("the Association") had failed to deal adequately with a leak in the roof of its building which has caused damage to his flat and necessitated a temporary drainage pipe to be installed to divert the rainwater and prevent further damage. He complained that there was an undue delay on repairing the problems and that there was also a lack of communication from the Association.

The investigation found that whilst there had been delays in repairing the leaking roof, this was due to liability issues surrounding the defective roof and other matters regarding safe working access to the roof in accordance with health and safety legislation.

The Ombudsman recommended that the Association should:
a) write Mr F a letter detailing the current situation regarding the leaking roof, confirming that the matter is being given priority by the Housing Association, and
b) confirm that it will rectify any damage caused as a result of the leaking roof and temporary works

The Association agreed to do this and also offered Mr F an ex gratia payment of £175 for the inconvenience he had experienced so far.

**Cardiff Council - Repairs and maintenance (inc dampness/improvements and alterations e.g. central heating. double glazing)**

**Case reference 201503564 - report issued in December 2015**
Mr S complained about several aspects surrounding a visit by an operative of Cardiff Council ("the Council") to carry out repair work. Mr S had made a complaint to the Council. It responded to him apologising for any distressed caused and informing him that the operative had been spoken to and reminded of the correct procedures. After considering the contents of the complaint, the Ombudsman asked the Council to offer Mr S a time and trouble payment for any inconvenience caused.

The Council agreed to offer a payment of £25.

**Linc-Cymru Housing Association - Repairs and maintenance (inc dampness/ improvements and alterations e.g. central heating. double glazing)**
**Case Reference 201504058 – report issued in December 2015**
Miss G complained that Linc-Cymru had unnecessarily delayed the completion of repairs at her rental property. Miss G complained also that Linc-Cymru having agreed to complete re-plastering works at the property unfairly reversed its decision. In consequence Miss G had to arrange for completion of the re-plastering works at her own expense.

Having considered the complaint, the Ombudsman asked Linc-Cymru to:

a) complete the outstanding repairs at Miss G's property
b) reimburse Miss G for the re-plastering works completed at her own expense (which they had previously agreed they would complete)
c) pay £100 to Miss G in recognition of the time and trouble taken in pursuing her complaint.
Linc-Cymru agreed to these proposals and conveyed its apologies to Miss G.

## Planning and Building Control

## Upheld

**Gwynedd Council – Rights of way and public footpaths**
**Case Reference 201408366 - Report issued in November 2015**
Mr P complained to the Ombudsman that the Council had failed to ensure the removal of a gate across a public highway over a period of some 17 years. He also complained that the Council had amended a definitive map without the appropriate orders and had failed to appropriately explain its decision that the route did not benefit from a public right to drive motor vehicles along it.

The Ombudsman found that the Council had not amended the official definitive map for the route in question. However, it had failed to update a working copy of the map (which had no official status) which it held and that this had contributed to a failure to remove the gate. He also found other delays in taking steps to remove the gate. The Council had provided a rationale for its decision that the route in question did not benefit from a public right to use motor vehicles across it although it was not the role of the Ombudsman to determine whether such rights existed. The Ombudsman upheld the aspects of the complaint that related to the delay of 12 years in ensuring the removal of the gate.

The Ombudsman recommended that the Council:
a) apologise to Mr P and pay him redress of £3,600
b) amend its procedures to ensure that any changes made to its maps were recorded appropriately.

The Council accepted the recommendations.

**The Planning Inspectorate Planning and Building Control - Other planning matters**
**Case Reference 201404423 – Report issued in December 2015**
Mr D complained about the Planning Inspectorate's ("the Inspectorate") decision to grant permission for the retention of timber decking and fencing in the rear garden of a property which was adjacent to his rear garden and at a higher elevation. He was concerned that the Inspector failed to consider a previous relevant appeal decision which Mr D had brought to the Inspector's attention and had not researched the planning history for the site.

The Ombudsman found that there would be an expectation that a local planning authority would provide details of the planning history of a site in its response to an appeal. He did find that the Inspector failed to have regard to a previous appeal decision and this had led to some uncertainty about whether the outcome would have been different. He upheld this complaint. The Inspectorate agreed to apologise to Mr D for the Inspector's failure to refer to the previous appeal decision.

## Not Upheld

**Cardiff Council – Unauthorised development**
**Case reference 2014054054 - Report issued October 2015**
Mr X is the owner of a bar operating on the upper floors of a row of terraced properties in a town centre. He complained about Cardiff Council's ("the Council") failure to enforce conditions attached to the planning consent for the change of use of the upper floors of the next door property to apartments.

The Ombudsman found that there might have been a breach of the conditions and there had been significant delay in the Council considering whether to take enforcement action. However, he noted that enforcement action by a planning authority is discretionary, and did not consider the decision not to take such action to be so clearly unreasonable as to be perverse. He did not uphold the complaint.

## Quick fixes & voluntary settlements

**Carmarthenshire County Council – Other planning matters**
**Case reference 201503742 – Report issued in November 2015**
Mr S complained that Carmarthenshire County Council ("the Council") had failed to enforce planning conditions in respect of a Wind Farm in the Ammanford area. He also complained that the Council had not responded to his complaint in a timely and satisfactory manner.

The Ombudsman was not satisfied that there had been any hardship or injustice suffered by Mr S as a result of the Council's failure to enforce the conditions. However, he was satisfied that the Council had failed to respond in a timely and satisfactory manner to his complaint.

He recommended that the Council should:

a) write a letter of apology to Mr S
b) offer a payment of £250 for time and trouble taken by Mr S in making his complaint.

**Wrexham County Borough Council - Unauthorised development - calls for enforcement action etc.**
**Case reference 201406352 - report issued in December 2015**
Mr B submitted a complaint to the Ombudsman as he was dissatisfied with Wrexham County Borough Council's ("the Council") response to his complaint. He said that its response was insulting and derogatory and based on a number of telephone conversations which Mr B disputes took place. This aspect of his complaint was not upheld as it was unlikely that the Ombudsman would be able to reach a conclusive finding.

Mr B also raised concerns about the actions and conduct of various members of staff which he

said showed a lack of respect towards him. This aspect of his complaint was not upheld as the Ombudsman is unable to take action in respect of staff conduct or discipline matters.

Finally, Mr B raised concerns about the contents of an internal email sent on 24 March 2014. The Ombudsman contacted the Council which agreed to provide Mr B with a written apology within 20 working days.

**Cardiff Council – Other planning matters**
**Case reference 201504008 - report issued in December 2015**
Ms J complained that a fence that had been erected between her home and her neighbour, preventing them from looking into her bedroom window, collapsed in the spring and was reported to Cardiff Council ("the Council") in April 2015. Ms J said she had complained to the Council on a number of occasions but at the time of bringing her complaint to the Ombudsman the fence had still not been repaired or replaced.

On receipt of this complaint, the Ombudsman contacted the Council to discuss these concerns. He was advised that the Officer dealing with this matter had sought authorisation to pursue enforcement action against the neighbour compelling them to undertake the necessary works and that failure to comply with the enforcement notice is an offence.

The Ombudsman believed that the action which the Council said it would take was reasonable and would resolve this complaint. Accordingly, he considered the matter to be settled. However, Ms J was advised to come back to the Ombudsman if the action promised by the Council did not materialise or was unsatisfactory.

**Carmarthenshire County Council - Planning and Building Control - Handling of planning application (other)**
**Case Reference 201504222 – Report issued in December 2015**
Mrs J complained that the Council had failed to deal correctly with a planning application for a change of use of a nearby dwelling into a part dwelling/commercial use property. She complained that the Council had failed to include the planning history, that inaccuracies in the application were not addressed and that it did not comply with the unitary development plan.
Mrs J also complained that the Council had failed to deal with her stage 2 complaint in a timely manner.

The Ombudsman was satisfied that there was no maladministration by the Council in relation to its handling of the planning application. He did, decide, however that there had been an undue delay by it in dealing with Mrs J's complaint. A recommendation was made that the Council should make an offer of £250 as an ex gratia payment for the time and trouble taken in making her complaint.It agreed to do so.

## Roads and Transport

## Quick fixes & voluntary settlements

**Welsh Government – Other**
**Case reference 201504263 - report issued in December 2015**
Mr C complained that traffic officers from the North and Mid Wales Trunk Road Agency had unlawfully caused his boat trailer to be removed from the side of the A55 Highway.

He further complained that there were undue delays in dealing with his complaint as there was confusion surrounding who was responsible as an authority for the removal of the trailer and managing his complaint.

The investigation revealed that the traffic officer had acted reasonably and that this element of the complaint was not upheld. In relation to the complaint handling, the Ombudsman made the following recommendations, which the Welsh Government agreed to implement:

a) write a letter of apology to Mr C apologising for the undue delays in dealing with his complaint
b) ensure that access to the Welsh Government's complaint process is included on both Trunk Road Agency websites. (This should be included in the letter to Mr C.)
c) make on offer of £250 as an ex gratia payment in recognition of the time and trouble taken by him in pursuing his complaint.

## Self-funded care

## Upheld

**Hawthorn Court Care Ltd in respect of Hawthorn Court Care Home**
**Case Reference 201408665 - Report issued October 2015**
Solicitors acting on behalf of Mrs Q, the daughter of a former resident (Mrs P) of Hawthorn Court Care Home ("the Care Home") requested that Hawthorn Court Care Ltd (the Provider) provide them with Mrs P's care records for the period of her residence in the home. The Solicitors received no response to this request and numerous further requests for the Care Home to provide the records over a period of some 18 months.

The investigation found that the Provider had failed to respond to the solicitors request and had been unable to locate the records in question during this period. During the course of the investigation however the Provider was able to locate the records. The Ombudsman found this to be maladministration leading to injustice both in terms of the failure to respond to the request and to locate the records. He upheld the complaint and recommended that the Provider:

a) apologise to Mrs Q for the shortcomings identified and pay her redress of £500
b) take steps to develop a robust process for securely managing and retrieving historical service user records
c) consider making Mrs P's records available to Mrs Q via the Solicitors

## Social Services - Adult

## Upheld

**Pembrokeshire County Council/Hywel Dda University Health Board - Other**
**Case References 201404540/201409309 – Report issued in November 2015**
The Ombudsman investigated a complaint from Mr Y about Pembrokeshire County Council's ("the Council") actions concerning the Deprivation of Liberty Safeguards ("DoLS") and Hywel Dda University Health Board's ("Health Board") delays in agreeing continuing health care ("CHC") funding to enable his wife to be cared for at home.

The Ombudsman upheld the complaints against both bodies. He found failings in the way in which the Council, as supervisory body for the DoLS process, carried out its role. He found delays on the part of the Health Board, both in making the application to the funding Panel and in the funding being agreed. Taken together, the failings meant Mrs Y had remained in a care home for longer than she should have.

The Ombudsman recommended that both bodies should:

a) work together to address the failings and to identify improvements to ensure they did not re-occur
b) apologise to Mr Y, and
c) make a payment of £1000 to him to reflect the distress caused and his time and trouble in pursuing the complaint.

**City and County of Swansea - Adult Social Services**
**Case reference 201500475 – Report issued in December 2015**
Ms W is a parent who suffers regular uncontrolled seizures. She had been receiving direct payments from Social Services over a number of years to enable her to maintain her independence and to care for her children. In 2012, the Council considerably reduced these payments. Ms W complained about the manner in which her need for direct payments had been reviewed and reassessed.

The Ombudsman found numerous shortcomings in the Council's actions. There had been an ongoing failure to adequately review Ms W's and the children's needs over a number of years. There was an absence of joint working between Child and Family and Adult Services. The decision to cut Ms W's care package was not based on proper assessment of the family's and Ms W's needs. It is for the Council to decide the level of care required to appropriately meet Ms W's needs; however this decision needs to be based on a robust assessment. The Ombudsman upheld the complaint and made a number of recommendations including:

a) a written apology for Ms W
b) completion of a robust assessment for Ms W, including a risk management plan, input from health colleagues and other services (such as occupational therapy), and adequate ongoing monitoring and review arrangements

c) a review of the Council's procedures and practice to ensure compliance with current legislation and guidance, particularly in terms of: joint working between departments; reviews; carers' assessments and dispute resolution.

The Council accepted the findings of the report and agreed to implement the Ombudsman's recommendations.

**The Vale of Glamorgan Council – Adult Social Services**
**Case Reference 201501394 – Report issued in December 2015**

Mr A complained that his mother's estate had been reduced by £55,000 because the Council's Social Services Department had not carried out a financial assessment to determine her contribution towards her nursing home fees when she moved into a nursing home in 2007, despite initially saying that it had. Additionally, the Council had not correctly applied the Welsh Government's Charges for Residential Accommodation guidance which would have led to capital from his mother's insurance investment bonds being disregarded. His mother therefore paid for her care.

In June 2011, although the Council had carried out a financial assessment which reduced his mother's contributions towards her nursing home fees, it was unwilling to carry out a reassessment back to 2007. Mr A also complained about the Council's handing of his complaint.

The Council in settling this case accepted a financial assessment should have been carried out in 2007. It determined that its liability for nursing home costs equated to £45,301.81. As Mr A's mother would not have been entitled to certain benefits the Council agreed to repay the Department of Works and Pension £14,031.89 from this sum with the balance of £31,269.92 being repaid to Mr A and the family.

In recognition of the distress, time and trouble and mistakes in decision-making the Council said that it would pay Mr A and the family £500. As part of the settlement the Council agreed it would publicise the issues in this case, produce a public information leaflet and share the points of learning both individually and collectively with staff within the Council.

## Social Services - Children

## Upheld

**Isle of Anglesey County Council – Children's Social Services**
**Case Reference: 201403368 – Report Issued in October 2015**
Mrs A complained about the support provided to her and her two sons by Isle of Anglesey County Council's ("the Council") Social Services Department from January 2012 until they were removed from the child protection register in April 2013.

The Ombudsman found that the support provided by the Council was broadly appropriate. However, he did identify some failings in relation to whether consideration should have been given at an earlier stage to reallocating the case to a different social worker after the relationship with the family broke down.

This meant that the family did not receive direct input or oversight from a social worker for six months. In addition, the Ombudsman found some failings in relation to communication with the family about the boys' core assessments and the recording of why information about the child protection process was being withheld from Mrs A. The Ombudsman partly upheld the complaint.

The Ombudsman recommended that the Council should apologise to Mrs A and her sons for the failings identified. He also recommended that managers in the Department be reminded of the need to consider the potential implications of refusing requests to change social workers and should amend its procedures so that when a client refuses to co-operate with the production of a core assessment, a copy of the draft assessment is still shared with the client in order to provide them with an opportunity to comment on or challenge the content.

**Isle of Anglesey County Council – Other**
**Case Reference 201406034 – Report issued in October 2015**
Mr and Mrs A complained that Isle of Anglesey County Council ("the Council") shared unsubstantiated allegations about Mr A with a fostering agency that had accepted them as prospective foster carers. They said that this was despite the allegations not being properly investigated at the time they were made some years ago. Mr and Mrs A also complained about the Council's response after they raised concerns about its actions.

The Ombudsman partly upheld the complaint. It was clear that there was a failure to properly record or investigate the allegations when they were originally made. In addition, when the fostering agency contacted the Council for references for Mr and Mrs A, the Council did not pass on the allegations at that point. It was only some time after the fostering agency had approved Mr and Mrs A as foster carers that the Council made it aware of the allegations.

The Council was also not as open as it could have been with the Agency and Mr and Mrs A about the allegations, and its consideration of their complaint could have been more robust. The Ombudsman found, however, that the Council was justified in sharing the allegations with the fostering agency in view of its obligations under the child protection procedures.

The Ombudsman recommended that the Council should:

a) apologise to Mr and Mrs A and pay them £1,500 to reflect the uncertainty, frustration and distress caused by the Council's maladministration
b) contact Mr and Mrs A to take forward a previous offer to agree a standard reference
c) provide him with evidence that it has robust processes in place to ensure it can identify and pass on to potential employers any child safeguarding concerns relating to current or former employees
d) present the case to the Regional Child Practice Review Group for consideration of whether a Multi-Agency Professional Forum should be held to promote wider learning from the case.

**Powys County Council - Other**
**Case reference 201501046 - report issued in December 2015**

Mr X complained about Powys County Council ("the Council") "flagging" his name on its database as being a risk to children, even though he denied allegations which had been made against him and had not been convicted of any crime. Mr X also said that he had not been told how to challenge the decision.

Mr X also complained that a specialist risk assessment by the Council was not carried out in a timely fashion and restricted his contact with his child. Mr X also complained that the Council incorrectly claimed that his court appeal against the revocation of his taxi licence also dealt with the issue of his flagged status.

The Ombudsman found that the Council's decision to flag Mr X's name was taken appropriately, but that it had failed to properly set out his right to challenge the decision annually. The Ombudsman found no evidence that the Council had said that the court had considered Mr X's flagged status. The Ombudsman did not uphold these complaints. The Ombudsman found that the delay in undertaking the risk assessment was excessive and avoidable. The Ombudsman upheld this complaint.

The Ombudsman recommended that the Council should:

a) apologise to Mr X
b) pay Mr X financial redress of £200, in respect of the delayed specialist risk assessment
c) remind all relevant staff of the importance of comprehensively recording the rationale for decisions taken
d) complete its review, drafting and adoption of its policies and procedures in respect of flagging potentially risky adults on its database
e) review its resources in relation to child protection investigation/risk assessments.

## Not Upheld

**Denbighshire County Council - Children in care/taken into care/'at risk' register/child abuse/custody of children**
**Case reference 201402085 - report issued in December 2015**
Mr and Mrs X complained that Denbighshire County Council ("the Council") had failed to act in accordance with applicable child protection procedures and legislation, during the period 31 December 2010 to 6 December 2012.

Mr and Mrs X said that this led to child protection action being unreasonably escalated, subjecting them to avoidable distress and irreparably damaging their family unit.

The Ombudsman found that, overall, the Council had acted in accordance with procedure and had acted appropriately in relation to child protection intervention. Whilst the Ombudsman found some evidence of administrative errors on the Council's part, he was satisfied that these did not materially affect its overall approach or the ultimate outcome.

The Ombudsman did not uphold the complaint.

## Quick fixes & voluntary settlements

**CAFCASS Cymru – Children in care/taken into care/'at risk' register/child abuse/ custody of children**
**Case Reference 201503553 - Report issued in October 2015**
The Ombudsman had referred Ms X's original complaint to him in June 2015 to CAFCASS for its consideration. Ms X now complained that she had not received a response.

On receipt of Ms X's most recent complaint, CAFCASS were contacted for information. Unfortunately, it appeared that CAFCASS had not received the letter referring Ms X's original complaint of 10 June 2015. It agreed to provide a full response to Ms X.

**Wrexham County Borough Council - Other**
**Case Number 201502823 - Report issued in October 2015**
Ms A complained that there was a lack of communication from Wrexham County Borough Council's ("the Council") Occupational Therapy Service during the disabled facilities grant process and said it had failed to fully address her concerns about the OT assessment and the service provided. Ms A therefore questioned the adequacy of the OT assessment carried out as part of the process.

Having considered the information provided on behalf of the complainant, the Ombudsman approached the Council on the basis that it appeared that there were outstanding issues that it had not responded to. The Council agreed to settle the complaint by providing a fuller response to Ms A and by explaining the conclusions of the OT assessment. It also agreed to enter discussions with Ms A to explore what options could be pursued, now that the initial application had been unsuccessful.

The Ombudsman concluded that the action which the Council said it would take was reasonable to settle the complaint and closed the file on this basis.

**Newport City Council – Social Care Assessment**
**Case reference 201503460 – report issued in December 2015**
Mrs X complained that she had been denied the opportunity to progress her complaint to Stage 2 of the Social Services Complaints Procedure relevant at that time ("Listening & Learning").
In view of the initial concerns identified, the Ombudsman invited Newport City Council ("the Council") to settle the matter by writing to Mrs X offering her the opportunity to request a Stage 2 formal investigation of her complaint. The Council also agreed to provide Mrs X with the details of the Advocacy Services available to assist her with her complaint.

**Torfaen County Borough Council - Children's Social Services**
**Case reference 201503989 – Report issued in December 2015**
Mrs A complained about the manner of a joint interview conducted by the Police and Social Services with her six year old grandson following his disclosure that he had been harmed by a neighbour. She was also concerned about the Council's handling of her complaint about the matter.

On receipt of the complaint, the Ombudsman contacted the Council and it agreed to:
a) apologise and pay Mrs A £250 to for the poor handling of her complaint outside of the appropriate procedure and for any unnecessary time and trouble this had caused; and
b) make swift arrangements for an independent stage two investigation of her complaint to be carried out.

## Various Other

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

**Cynwyd County Council - Poor/No communication or failure to provide information**

**Case reference 201403092 – Report issued in November 2015**

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

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

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

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

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

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

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

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

## Upheld

**Abertawe Bro Morgannwg University Health Board – Poor/no communication or failure to provide information**
**Case Reference 201409395 – Report issued in October 2015**
Ms D complained about a number of aspects of the care provided to her father by Abertawe Bro Morgannwg University Health Board ("the Health Board") from 25 February 2014 until his sad death on 31 March. These included concerns about delays in Mr D's surgery and in arranging a CT scan and contradictory information she said she was given regarding her father's chest infections.

Ms D also questioned whether adequate oral care had been given to Mr D and whether he should have been on the sepsis pathway. Ms D raised concerns about whether Mr D's surgical wound was managed appropriately, the follow up from the CT scans and delays in the death certificate being signed. Ms D also raised concerns about the handling of her complaint by the Health Board.

The Ombudsman found that Mr D's surgery and CT scan were carried out within a reasonable timeframe. As there was no record of what Ms D had been told regarding Mr D's chest infections, the Ombudsman could not say she had not been given conflicting information. He upheld the complaint. He was also critical of the standard of record keeping, particularly in relation to discussions with the family about prognosis. The Ombudsman was satisfied that Mr D received appropriate and timely treatment for an oral hygiene issue and found that there was no clinical indication for Mr D to have been on the sepsis pathway. The Ombudsman found that follow up from CT scans would not usually have been given as the results were normal and the death certificate was issued within the usual timescales. Mr D's wound was managed appropriately.

## Quick fixes & voluntary settlements

**Student Finance Wales - Other miscellaneous**
**Case Reference 201503727 – Report issued in November 2015**
Mr A complained that Student Finance Wales ("SFW") had refused his request to carryover 40 hours of unused learning support into the new academic year, after it had failed to respond to his request to be allowed to use the hours over the summer break. Although Mr A had asked for his complaint to be escalated to stage two of its published complaint procedure, this had not happened.

On receipt of the complaint, the Ombudsman contacted SFW and it agreed to escalate Mr A's complaint to be considered under stage two of its complaint procedure.

# More information

Full reports can be found on our website: www.ombudsman-wales.org.uk. If you cannot find the report you want, you can request a copy by emailing ask@ombudsman-wales.org.uk.
We value any comments or feedback you may have regarding The Ombudsman's Casebook. We would also be happy to answer any queries you may have regarding its contents. Any such correspondence can be emailed to Matthew.Aplin@ombudsman-wales.org.uk or Lucy.Geen@ombudsman-wales.org.uk, or sent to the following address:

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

Tel: 01656 644200
Fax: 01656 641199
e-mail: ask@ombudsman-wales.org.uk (general enquiries)

Follow us on Twitter: @OmbudsmanWales

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