

## **The Vale of Glamorgan Council**

### **Standards Committee: 22 November 2018**

#### **Report of the Monitoring Officer / Head of Legal and Democratic Services**

#### **Public Services Ombudsman for Wales' Annual Report and Accounts 2017/18**

##### **Purpose of the Report**

1. To present to Members extracts from the Annual Report and Accounts for the Public Services Ombudsman for Wales for the year ending 31st March, 2018 in respect of Members' Code of Conduct matters.

##### **Recommendation**

That the contents of the report be noted.

##### **Reason for the Recommendation**

To inform Members of the Standards Committee.

##### **Background**

2. The Annual Report is a combined report addressing matters relating to the dual functions of the Public Services Ombudsman for Wales (the Ombudsman). The link to the full Annual Report can be found at <https://www.ombudsman.wales/wp-content/uploads/2018/07/PSOW-Annual-Report-and-Accounts-2017-2018.pdf>

##### **Relevant Issues and Options**

3. There are two elements to the role of the Ombudsman, which are to consider complaints about public service providers in Wales and to consider complaints of members of Local Authorities who have breached their Authority's Members' Code of Conduct.
4. With particular reference to Members' Code of Conduct complaints, the Ombudsman may consider complaints about the behaviour of:
  - County and County Borough Councils;
  - Community Councils;

- Fire Authorities;
  - National Park Authorities;
  - Police and Crime Panels.
5. The Annual Report notes that all the Authorities' Members' Code of Conduct set out in detail how Members must follow recognised principles of behaviour in public life. The Ombudsman further states that if a County Council wishes to make a complaint about another County Council in their own Authority, he would expect them first of all to make their complaint to that Authority's Monitoring Officer as it may be possible to resolve the matter locally without the Ombudsman's involvement.
  6. Members' attention is drawn to pages 1-27 of the Annual Report which are attached at Appendix 1 to this report and provide a snapshot of the year 2017/18.
  7. Annex B to the Annual Report, attached at Appendix 2 to this report, provides details of Code of Conduct Complaints that have been closed with a statistical breakdown of outcomes by Local Authority, with a summary of the statistical breakdown specific to the Vale of Glamorgan Council and the Town and Community Councils within the Vale of Glamorgan as detailed at Appendix 3.
  8. The Full Annual report has not been reproduced in its entirety as the remaining sections refer primarily to internal governance arrangements and financial matters.

### **Resource Implications (Financial and Employment)**

9. None as a direct result of this report.

### **Sustainability and Climate Change Implications**

10. None as a direct result of this report.

### **Legal Implications (to Include Human Rights Implications)**

11. None as a direct result of this report.

### **Crime and Disorder Implications**

12. None as a direct result of this report.

### **Equal Opportunities Implications (to include Welsh Language issues)**

13. None as a direct result of this report.

### **Corporate/Service Objectives**

14. This report relates to the role of the Standards Committee to promote and maintain high standards of conduct of Members as detailed in the Council's Constitution.

### **Policy Framework and Budget**

15. This is a matter for decision by the Standards Committee.

### **Consultation (including Ward Member Consultation)**

16. This report does not require consultation to be undertaken.

**Relevant Scrutiny Committee**

17. None.

**Background Papers**

None.

**Contact Officer**

Karen Bowen, Principal Democratic and Scrutiny Services Officer

**Officers Consulted**

None.

**Responsible Officer:**

Debbie Marles, Monitoring Officer / Head of Legal and Democratic Services



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## Ombudsman's Review of the Year

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It is with great pleasure that I present this combined annual report and accounts for the Public Services Ombudsman for Wales (PSOW) for the year ended 31 March 2018, which was my third full year in office. In accordance with paragraph 18 of Schedule 1 to the Public Services Ombudsman (Wales) Act 2005 (the Act), I have personal responsibility for the overall organisation, management and staffing of the office and for its procedures in relation to financial and other matters.

### **Progress in Innovation, Improvement and Influence: A Review of 2017/18**

Despite a challenging complaints context, I am delighted to be able to report positive progress in the activities of the office over the past year, with specific reference to our three-year strategic themes of innovation, improvement and influence, in what will be the final year of this corporate plan.

In terms of *innovation* the office made further progress on data analysis, data security and cyber security and has invested substantial resources in renewing and future-proofing our casework management system and developing a new website and intranet.

Our recently established Sounding Boards bedded down this year, providing very valuable insight from both healthcare provider and service user perspectives, and we established a local government sounding board which met for the first time.

The volume of health complaints coming to the office continues to be a concern. This year, whilst we've seen a welcome 2% reduction in the total number of complaints, complaints about health boards increased by 11%. The number of local government complaints fell by 10% for a further year.

The performance of most *improvement* bodies gives me some reason to be cheerful. Of the five health boards and two local authorities my Improvement Officers have been working with, I was delighted to see reductions against the overall health trend for Betsi Cadwaladr, Hywel Dda and Cwm Taf. There were, however, substantial increases in complaint volumes for both Abertawe Bro Morgannwg and Aneurin Bevan.

Continued pressure on the office as a result of increased numbers of health complaints has been an issue of real strain, resulting in a 11% reduction in the number of cases closed during the past year. Health complaints are generally more complex and there is often a need for clinical advice and multiple advisers, which can inevitably result in a longer investigation process.

However, it was also pleasing to see the number of cases of maladministration and service failure reduce in the course of the year, with 56% of investigated complaints upheld, compared to 61% in 2016/17.

Furthermore, only one improvement body, Hywel Dda Health Board, saw an increase in upheld complaints.

Early resolution and voluntary settlement continues to play an important part in providing administrative justice, now accounting for 63% of positive outcomes for complainants.

The variance in Health Board performance in complaint handling continues to give concern and therefore my office organised a special seminar for health complaints and best practice in June 2017, and a further seminar for all public services in the spring of 2018. At the latter event, I was very pleased to see further progress on Out of Hours services with the Rapid Response for Acute Illness Learning Set (RRAILS) project improving out of hours services in Health Boards across Wales, partly in response to my office's thematic report on the subject.

I published four public interest reports in the course of the year, all health related and two of which were in relation to Betsi Cadwaladr University Health Board.

In order to meet the needs of the people of Wales, my office can only function effectively by getting the best out of the talented people in its employ. During 2017/18 further developments were made to a new staff performance review and development process, with further investment in training including increased HR support, management training and coaching.

I am particularly pleased with the work conducted on developing PSOW internal values:

- Achievement – doing the best we can
- Togetherness – showing respect and collaborating for success
- Positivity – enthusiasm and pride about who we are and what we do

- Supportiveness – being there for each other and appreciating diversity
- Ownership – taking responsibility for everything we do
- Willingness – a keen and flexible can-do approach

In terms of our *influence* and collaboration with other bodies inside and outside Wales, I was delighted to host visits to the office from the Basque Ombudsman, the Local Government and Social Care Ombudsman for England and the Legal Ombudsman. I attended a workshop on own initiative investigations, hosted by the Dutch Ombudsman, in the Hague, and I also spoke at a seminar to promote peace and understanding between Georgia and Abkhazia in the Basque Country, an event supported by the Council of Europe.

I met with NHS and local government Chief Executives, monitoring officers and corporate complaints officers. In October I visited and addressed Flintshire Standards Committee and Cymdeithas y Feddygon (Welsh Speaking Doctors Society). In terms of broader stakeholder engagement, I was delighted that PSOW had a stand at the Urdd Eisteddfod in Pencoed and also a presence at the National Eisteddfod in my native Anglesey.

During the course of the year I met with Assembly Members from across the political spectrum and also gave evidence to the Equality, Local Government and Communities Committee and the Finance Committee of the National Assembly for Wales.

Having been elected to both the European and World Boards of the International Ombudsman Institute (IOI) I was also honoured to be elected Chair of the Ombudsman Association (OA) in May 2017.

Finally, during 2017/18 we saw welcome progress on stage 1 of the proposed new legislation governing my work. I was delighted to see the Plenary meeting of the National Assembly vote 47/1 in favour of the principles of the Public Services Ombudsman (Wales) Bill and I hope that further progress can be made during the year ahead. The combination of the challenging complaints context, experience of improvement activities and the possibility of additional legislative power will inform our strategic focus for the year ahead. The next corporate plan is likely to result in:

1. A concentration of improvement resources on bodies facing the greatest complaints challenges
2. A thematic specialisation of investigations to ensure that the office can continue to deal with high health volumes whilst not losing know how and efficiency in other areas
3. A continued focus on good practice and compliance



Nick Bennett  
Ombudsman

# SNAPSHOT OF THE YEAR 2017/18

## April

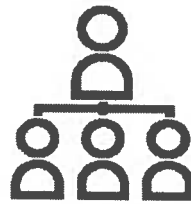
The Ombudsman met with the Welsh Government's new Permanent Secretary Shan Morgan



Llywodraeth Cymru  
Welsh Government

## May

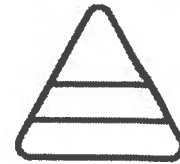
The Ombudsman is appointed Chair of the Ombudsman Association Executive Committee



## June

Hosted a complaint handling seminar for health bodies in jurisdiction

Took part in Urdd Eisteddfod in Pencoed



Urdd

## July

The first public interest report of the year was issued regarding Cwm Taf University Health Board



## August

Our annual report highlighted an 8% rise in NHS complaints

The second public interest report of the year was issued regarding Betsi Cadwaladr University Health Board



## September

Held the first PSOW Local Government Sounding Board





# SNAPSHOT OF THE YEAR 2017/18

## October

The Public Services Ombudsman (Wales) Bill is introduced by the National Assembly for Wales' Finance Committee

Two public interest reports are issued against two health boards



## November

The Ombudsman appears in front of the National Assembly for Wales' Equality, Local Government and Communities Committee for scrutiny of the 2016/17 Annual Report



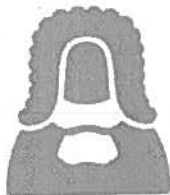
## December

The Ombudsman appears in front of the National Assembly for Wales' Equality, Local Government and Communities Committee to give evidence on the Public Services Ombudsman (Wales) Bill



## January

Attended the International Ombudsman Institute workshop on Human Rights in the Digital Age



## February

The Ombudsman hosted a spring seminar on complaint handling culture in Llandrindod Wells



## March

The general principles of the Public Services Ombudsman (Wales) Bill are agreed by the National Assembly for Wales



# Who we are, what we do

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## Role of the Public Services Ombudsman for Wales

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

## Complaints about public service providers

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

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

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

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

## Code of Conduct Complaints

Under the provisions of Part III of the Local Government Act 2000 together with relevant Orders made by the National Assembly for Wales under that Act, I consider complaints that members of local authorities have breached their authority's Code of Conduct. I am also a "prescribed person" under the Public Interest Disclosure Act for raising whistleblowing concerns about breaches of the Code of Conduct by members of local authorities. I can consider complaints about the behaviour of members of:

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

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

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

## Management Team

The Management Team has continued to support and advise me in relation to strategic direction as well as the operational, day to day, running of the office.

## Shared Services and Collaboration

My Finance, ICT and HR staff, who enable the delivery of our objectives, work collaboratively when appropriate, sharing professional knowledge through a network comprising Welsh Government sponsored bodies and Commissioners and they will continue to do so.

## Improvement Officers

In 2016, I introduced into the roles of a number of investigation staff in my office, the additional role of 'improvement officer'. Whilst the main element of their role remains the investigation of complaints, their improvement role includes stakeholder engagement with certain bodies in jurisdiction as well as subject leads for areas which continue to affect the quality of public services.

During 2017/18 organisations assigned an Improvement Officer were:

- Abertawe Bro Morgannwg University Health Board
- Aneurin Bevan University Health Board
- Betsi Cadwaladr University Health Board
- Ceredigion County Council
- Cwm Taf University Health Board
- Hywel Dda University Health Board
- Powys County Council

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

Subject leads were put in place for:

- health
- housing
- local government planning services
- social services
- school appeals
- the code of conduct for local authority members
- our service provision in the Welsh language, and
- recommendations and compliance

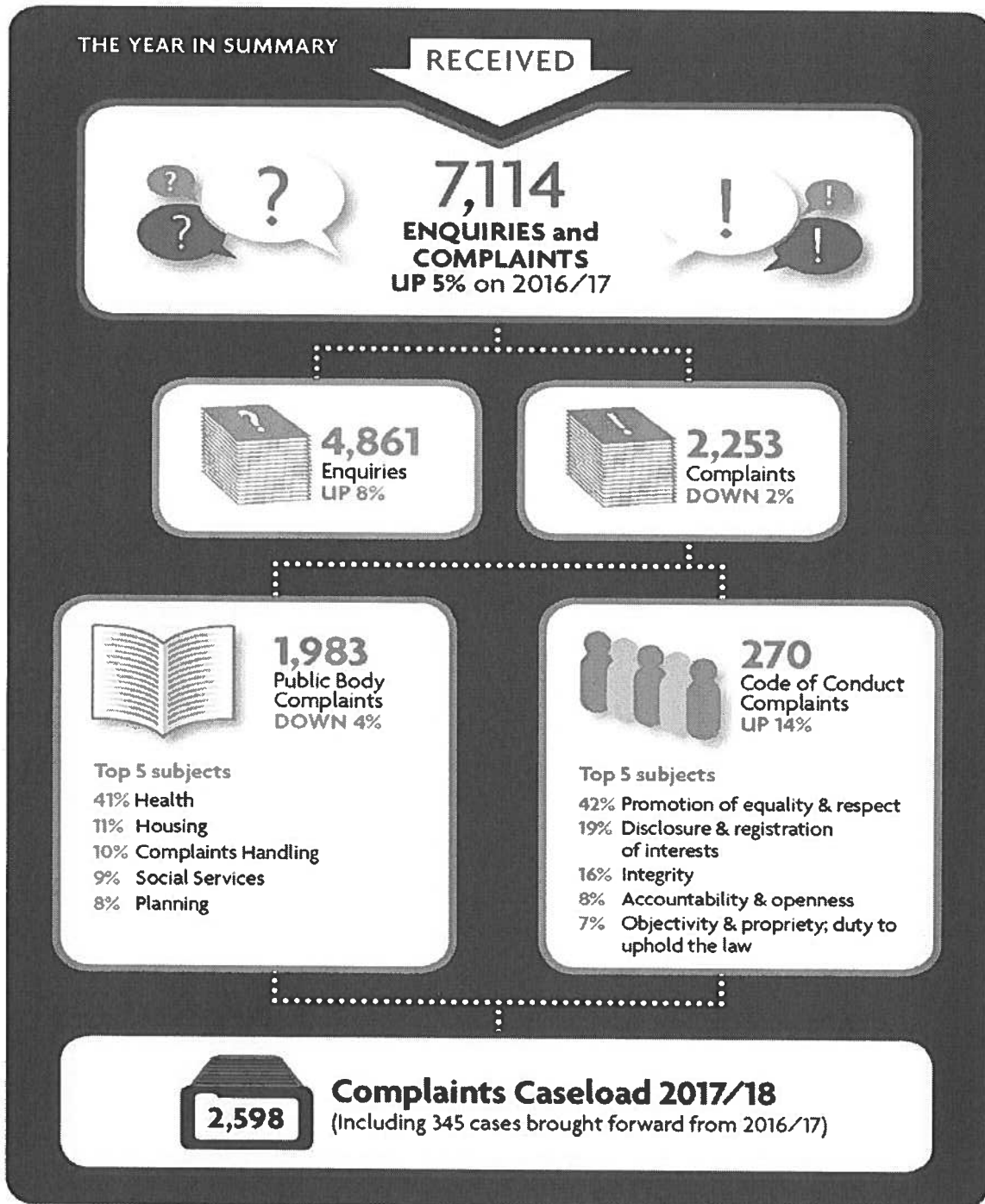
My improvement officers report a number of changes and improvements across health boards in the past year. A cultural change in the way in which Cwm Taf Health Board views complaints is emerging, with a keenness to engage with the Ombudsman and learn from complaints playing a role in this. The Health Board has embraced the closer involvement of the Ombudsman's Improvement Officer, with senior clinicians and nursing staff welcoming a presentation on the Board's performance and its relationship with the Ombudsman at its second annual "Listening and Learning from Concerns" seminar. In quantitative terms, the Health Board's performance in the timeliness of its responses to requests for information and in complying with the Ombudsman's recommendations has significantly improved.

One of my Improvement Officers has worked collaboratively with Ceredigion County Council on a complaint handling toolkit for internal use within the Council. It aims to improve the way in which complaints generally, and those which are made to my office, are handled, by promoting accountability and a culture which is receptive to complaints. I hope that the toolkit will prove to be a useful resource for the Council and other local authorities who wish to adopt a similar approach.

In engaging with other bodies, we hope to see ongoing improvements in complaints handling, learning and putting things right, along with further development of the governance arrangements necessary for continuous improvement.

For 2018/19 I have decided to concentrate the work of the improvement officers on a smaller number of public bodies most needing support.

# The Complaints Service





## Complaints Caseload 2017/18

(Including 345 cases brought forward from 2016/17)

CLOSED

**2,101**

**COMPLAINTS**

**DOWN 11% on 2016/17**



**1,854**

**Public Body  
Complaints  
DOWN 12%**



**247**

**Code of Conduct  
Complaints  
0%**

**497** detailed  
consideration/  
investigation  
**DOWN 9%**



**30** investigated  
**DOWN 32%**



**405** Resolution or Upheld  
**DOWN 12%**

Of these:

- 54% Health
- 13% Complaint Handling
- 10% Social Services
- 5% Housing
- 5% Planning

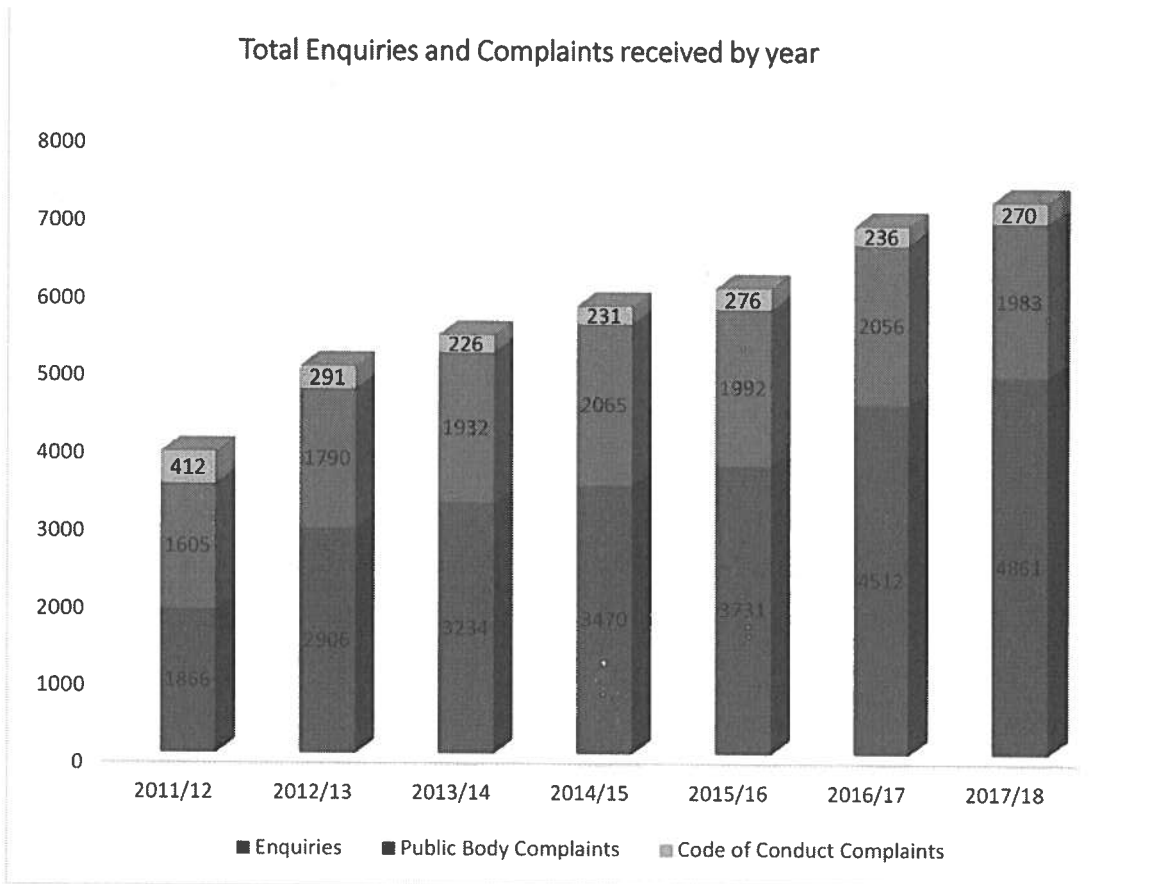
**13** Evidence of Breach  
**DOWN 41%**

Of these:

- 47% Promotion of equality & respect
- 30% Integrity
- 23% Disclosure & registration of interests

## Overall Casework Statistics

The overall number of enquiries and complaints (public body complaints, and complaints about the conduct of members of local authorities) has increased by 83% since 2011/12. In 2017/18 enquiries and complaints totalled 7,114, a 5% increase on the previous year.



Graph 1.1

### Enquiries

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

2017/18 saw the office deal with the highest number of enquiries since it was established. In total, there were 4,861 enquiries in 2017/18 compared to 4,512 in 2016/17 – an 8% increase. This may be explained by the higher visibility the office has experienced over the



past few years, both in terms of press activity and outreach, with more members of the public being aware of our service.

We set ourselves the target of answering our main line telephone calls within 30 seconds in 95% of cases. The team has performed well, answering 97% of calls within this timescale.

### **Public Body Complaints**

During 2017/18 we received 1,983 complaints about public service providers – a 4% reduction on the previous financial year. This reduces such complaints to the 2015/16 level when my office received 1,992 complaints. Whilst it is not possible to demonstrate a direct causal link, I am confident that the considerable work my office has undertaken with key public bodies, on the improvement agenda and cultural change, is now beginning to bear fruit.

Detailed breakdowns of the numbers of complaints received by public body can be found at Annex C.

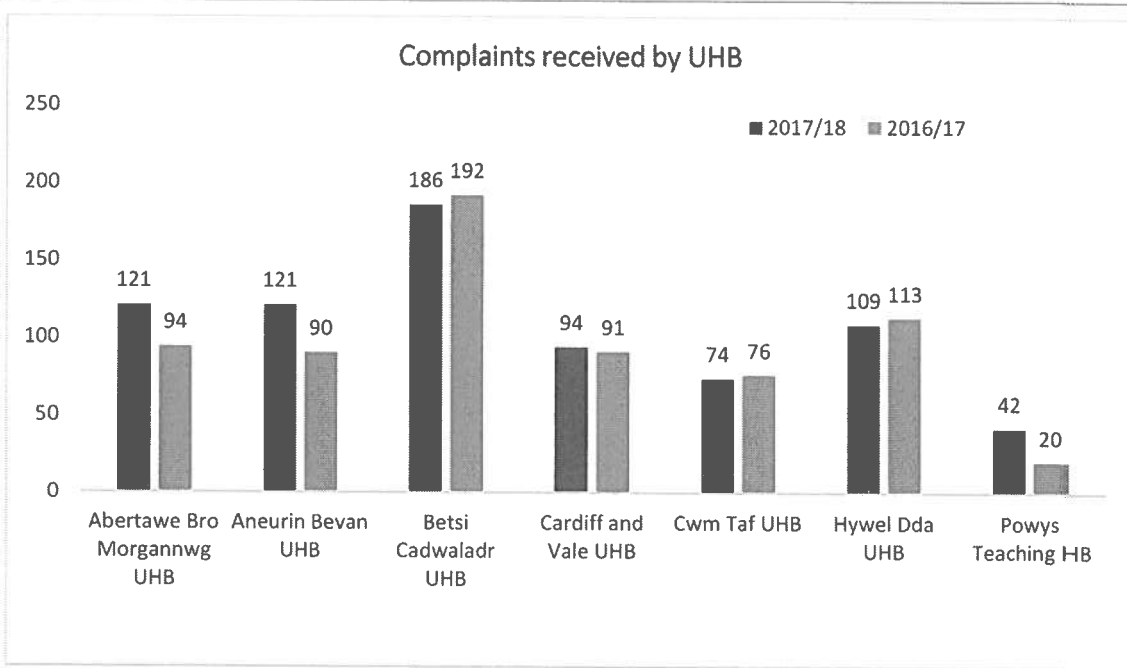
### **Sectoral breakdown of complaints received**

For the second year running, I am delighted to report a decrease in complaints against county councils. During 2017/18 my office received 791 complaints, compared with 881 in 2016/17 – a 10% drop. This year has also seen a considerable (28%) drop in social housing complaints compared to the previous year.

However, there has been an increase in the total number of complaints against NHS bodies, with 927 complaints made in 2017/18 compared with 863 in 2016/17. This represents a 7% increase. This is attributable to health board complaints which rose from 676 in 2016/17 to 747 in 2017/18 – an 11% increase.

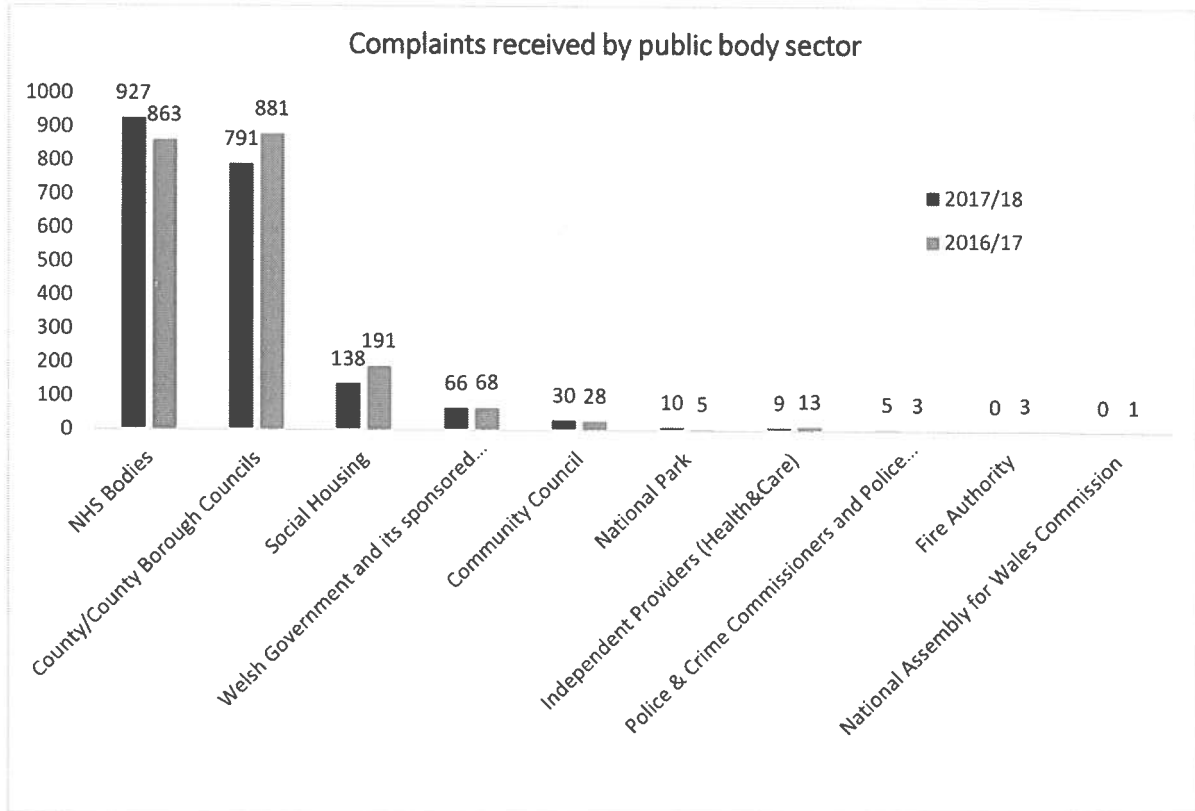
Graph 1.2 shows significant year-on-year increases in complaints received about Abertawe Bro Morgannwg (29%) and Aneurin Bevan University Health Boards (34%), as well as Powys Teaching Health Board (110%).

More encouragingly the graph shows that, despite the number of complaints received about Betsi Cadwaladr University Health Board remaining high, they have fallen moderately (3%) compared with the previous year. I am hopeful this trend will continue next year.



Graph 1.2

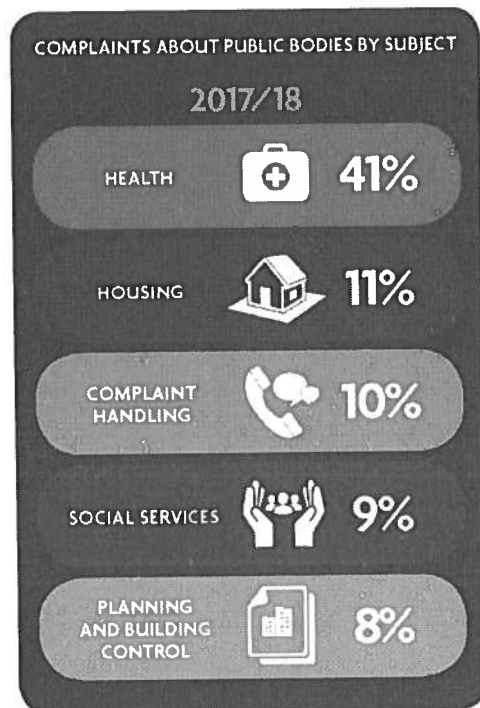
Graph 1.3 (below) shows the breakdown of complaints received by sector, together with comparisons with the previous year. NHS Bodies and County/County Borough Councils continue to dominate our caseload.



Graph 1.3

Complaints received about public bodies by subject

Turning to consider complaints by subject, rather than sector, unsurprisingly complaints about healthcare made up the largest part of our caseload. This trend has continued for a number of years. Complaints about healthcare increased from 38% of our caseload in 2016/17 to 41% in 2017/18. This was followed by complaints about housing services and complaint handling. Complaints about Social Services and Planning and Building Control are the other complaints subjects in the top five. These top five complaint subjects, together with the percentage of complaints they account for, are shown below.



The subjects of complaints received are shown in more detail in Chart 1.1 below.

### Complaints received about public bodies by subject

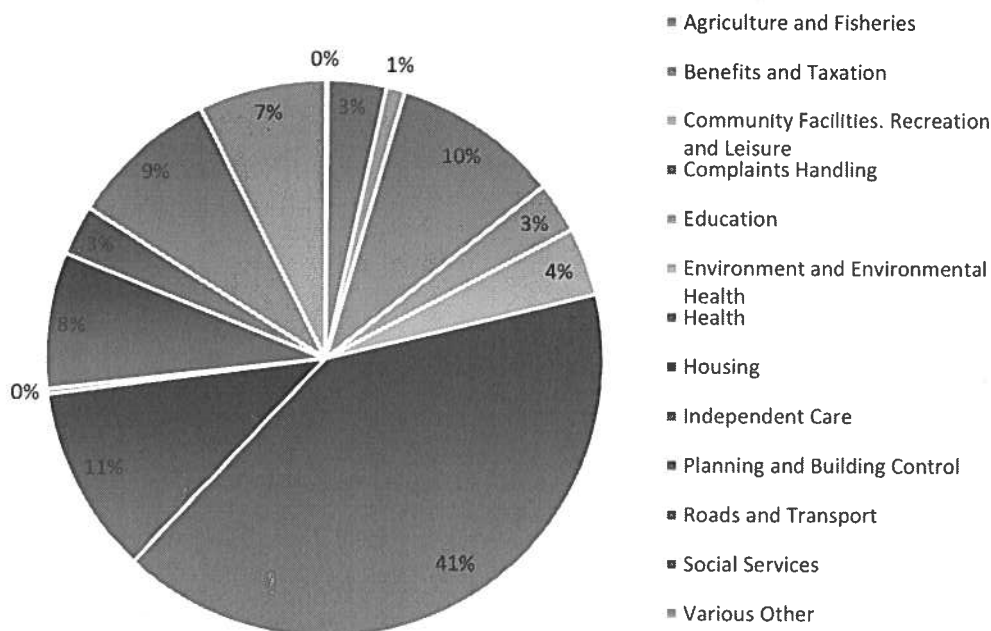


Chart 1.1

### Outcomes of complaints considered – cases closed during 2017/18

During 2017/18 we closed 1,854 complaints about public service providers, compared with 2,114 in 2016/17 (a reduction of 12%). This is a matter of some concern to me.

Complaints about healthcare are complex, time-consuming and, as indicated above, they are increasing in number. These significantly increase our workload for three reasons.

Firstly, we are less likely to be able to resolve a complaint or reach a decision about these complaints without securing additional information, including medical records, from the public body. To do this we must commence an investigation. Consequently, complaints about healthcare are five times more likely to require an investigation than complaints about other public services.

Secondly, these complaints are more complex and time-consuming to investigate. Since I am able to consider professional judgement in these cases, I will also generally need to seek professional clinical advice, often from more than one specialist. This extends the time needed to complete the investigation, as well as increasing the associated costs.

Thirdly, the subjects of many complaints about healthcare are sensitive and significant, often involving harm or the death of a family member. Health boards and clinical staff involved in the matters complained about will, quite rightly, want to ensure that their perspectives are fully and accurately reflected in our reports and decisions. The importance and significance of the matters considered in our healthcare investigations, and the fact that they involve professional judgement, are such that draft reports are more likely to be challenged by one or both of the parties. The important stage of inviting comments on our draft reports and proposed decisions is more time-consuming in complaints about healthcare than in other complaints. In some cases additional specialist advice may also be required.

The increase in the number of complaints about healthcare has, for these reasons, had a substantial impact on my investigation teams, reducing the number of cases closed whilst increasing the number of cases they are working on.

A summary of the outcomes is set out in table 1.1 below. The table shows that the number of straightforward complaints that could be closed after initial consideration was considerably lower than in the previous year. Whilst the number of investigations being progressed has increased, the number of investigations completed in the year was slightly lower than in 2016/17.

Detailed breakdowns of the outcomes by public service provider can be found at Annex A.

Complaints about a Public Body – Outcomes of cases closed	2017/18	2016/17
Closed after initial consideration	1357	1570
Complaint settled voluntarily	257	287
Investigation discontinued	8	16
Investigation: complaint not upheld	84	66
Investigation: complaint upheld in whole or in part	144	168
Investigation: complaint upheld in whole or in part - public interest report	4	6
Special report under Section 22 of the PSOW Act – public body failed to carry out actions it had previously agreed with the Ombudsman	0	1
<b>Total Outcomes - Complaints</b>	<b>1854</b>	<b>2114</b>

Table 1.1

Detailed breakdowns of the numbers of cases per local authority and health board where my office intervened (either by seeking an early resolution, settlement or by upholding a complaint following investigation) can be found at Annex D.

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## Decision times

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

We have set ourselves target times within which we will decide and tell complainants whether or not we will take up their complaints. As explained in the 2016/17 annual report, we changed our approach to ensure that we measure our performance in a way that reflects the service user's experience.

We aim to achieve the following times:

- Decision on whether complaint is within jurisdiction/premature - within three weeks.
- Decision on whether or not to investigate, following detailed assessment - within six weeks.
- Resolution of complaint, where we seek early resolution without the need to investigate - within nine weeks.
- Investigation start, where investigation is required – within six weeks of the Date Sufficient Information is Received (DSIR).

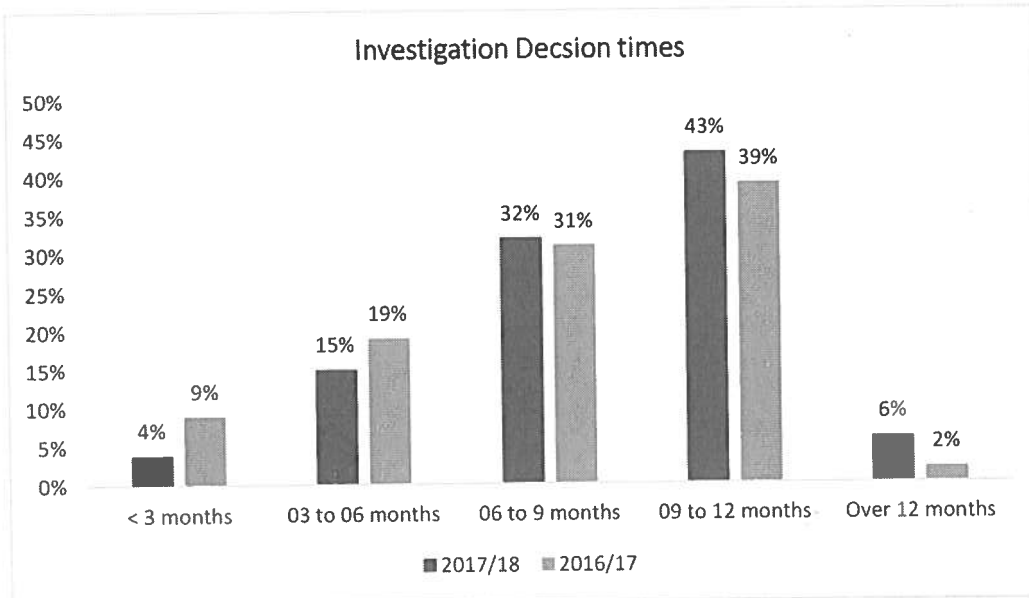
The following table shows the percentage of cases where we met these targets.

	Percentage 2017/18
Decision on whether complaint is within jurisdiction/premature – within three weeks	92%
Decision on whether or not to investigate, following detailed assessment - within six weeks.	89%
Resolution of complaint, where we seek early resolution without the need to investigate - within nine weeks	91%
Investigation start, where investigation is required – within six weeks of the Date Sufficient Information is Received (DSIR)	74%

**Table 1.2**

### Investigation Decision Times

In 2017/18 we completed 94% of investigations within 12 months. There were 17 investigations that took longer than 12 months. These cases were complex and required further investigatory work, or were cases where there were significant challenges, from the complainant or public body, to draft findings. Graph 1.4 gives further details of investigation timescales.



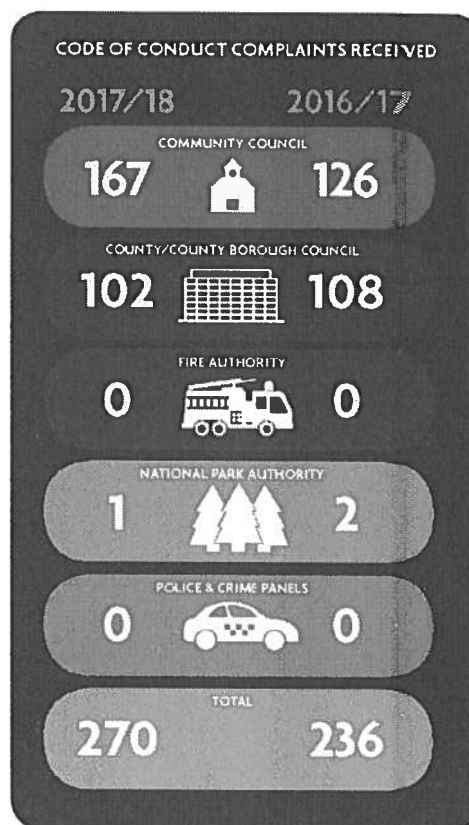
Graph 1.4

## Code of Conduct Complaints

The number of code of conduct complaints received increased to 270, an increase of 14% compared with 2016/17.

The increase relates entirely to Code of Conduct complaints involving Community Councils which have increased by 33%.

It is difficult at this stage to say exactly why there has been a significant rise in complaints about members of Town and Community Councils. Many of the complaints have arisen following changes in the membership of these council and difficulties have arisen between long established and new members. I am continuing to promote the concept of local resolution which has been adopted by a significant number of Town and Community councils, and I am encouraged by the efforts of One Voice Wales in this area which has, in collaboration with my office, created a model process for its members.





**Nature of Code of Conduct complaints received**

As in previous years, the majority of Code of Conduct complaints received during 2017/18 related to matters of ‘promotion of equality and respect’. These accounted for 42% of complaints (37% in 2016/17). Disclosure and registration of interests (19%) and integrity (16%) were the second and third most common types of complaint, which is consistent with the previous year. Chart 1.2 below provides a full breakdown of the nature of Code of Conduct Complaints received.

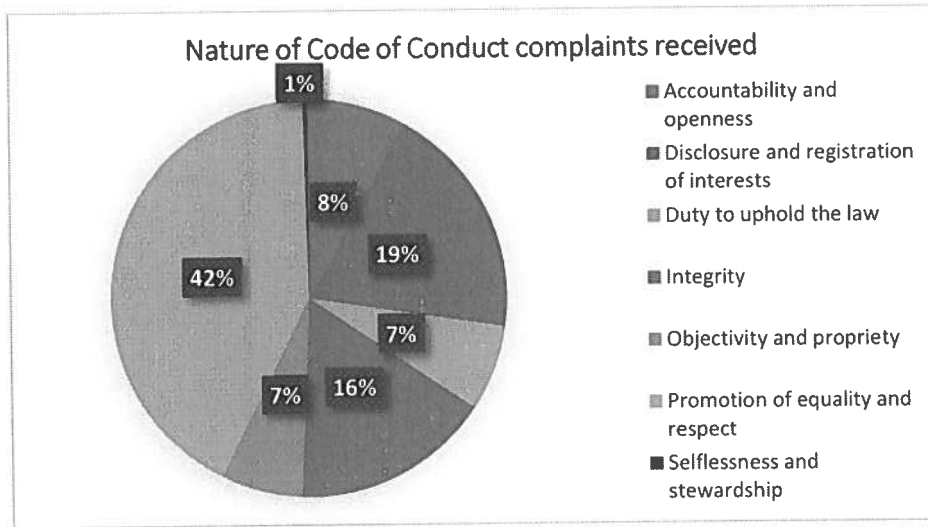


Chart 1.2

**Summary of Code of Conduct complaint outcomes**

The most common outcome is ‘Closed after initial consideration.’ Of the 247 complaints in 2017/18, the majority were closed (213) under this outcome. These include decisions where:

- there is no ‘prima facie’ evidence of a breach of the Code, and
- it is not in the public interest to investigate.

Fewer complaints were closed after full investigation in 2017/18 (26) than in 2016/17 (34). This is because I have continued to apply a public interest test when deciding whether to investigate Code of Conduct complaints. This means that I investigate only the more serious complaints where an investigation is required in the public interest.

In 2017/18 I received nine complaints which raised potential whistleblowing concerns about alleged breaches of the Code of Conduct. These complainants either did not provide ‘prima

facie' evidence of a breach of the code or did not warrant investigation in the public interest.

However, of the cases I investigated and closed this year, three cases were referred to the Adjudication Panel for Wales. The Adjudication Panel for Wales considers the evidence I prepare, together with any defence put forward by the member concerned. The Panel then determines whether a breach has occurred and, if so, what penalty, if any, should be imposed. Two of these cases were considered by the Panel during the year and in both cases serious breaches of the Code were found on the basis of my investigations and reports. Both cases involved councillors making derogatory remarks and unfounded allegations against staff and engaging in bullying, harassment, intimidation and malicious behaviour. As a result, a former member of Flintshire County Council was disqualified from holding office for 14 months and a former member of Conwy County Borough Council was disqualified from holding office for 18 months.

A summary of outcomes is below, with a detailed breakdown showing the outcomes of Code of Conduct complaints, by authority, provided in Annex B:



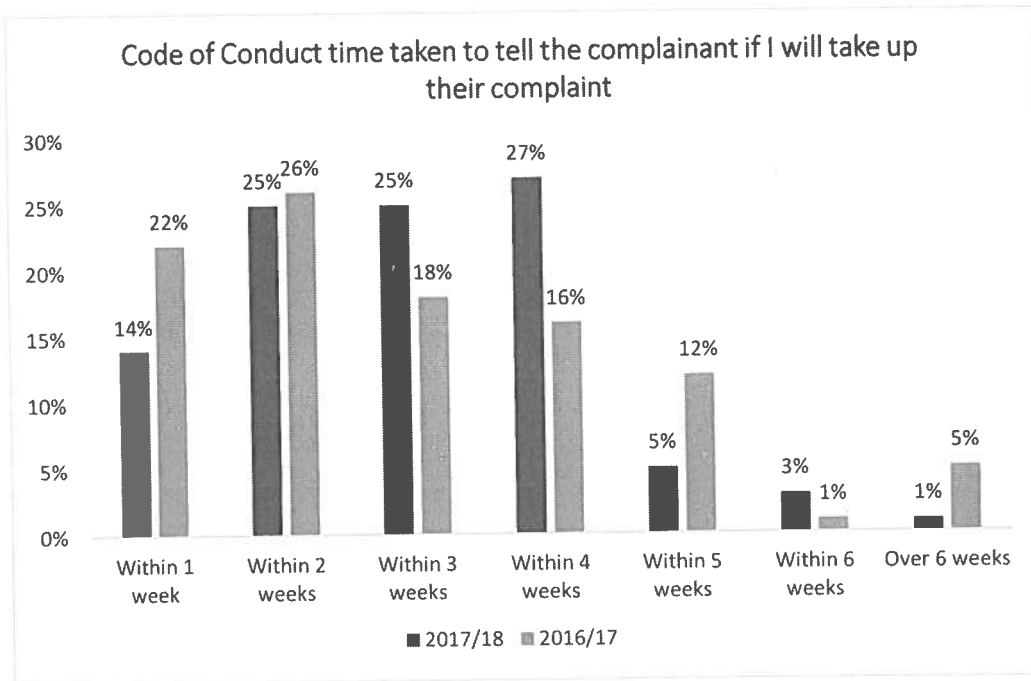
Decision times

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

In respect of Code of Conduct complaints, 91% of complainants were informed within four weeks of the date I received sufficient information of whether I would take up their complaint. I am pleased to report that this is considerably higher than during 2016/17 where 82% were informed within four weeks.

Further details on these decision timescales are shown below.

Code of Conduct time taken to tell the complainant if I will take up their complaint



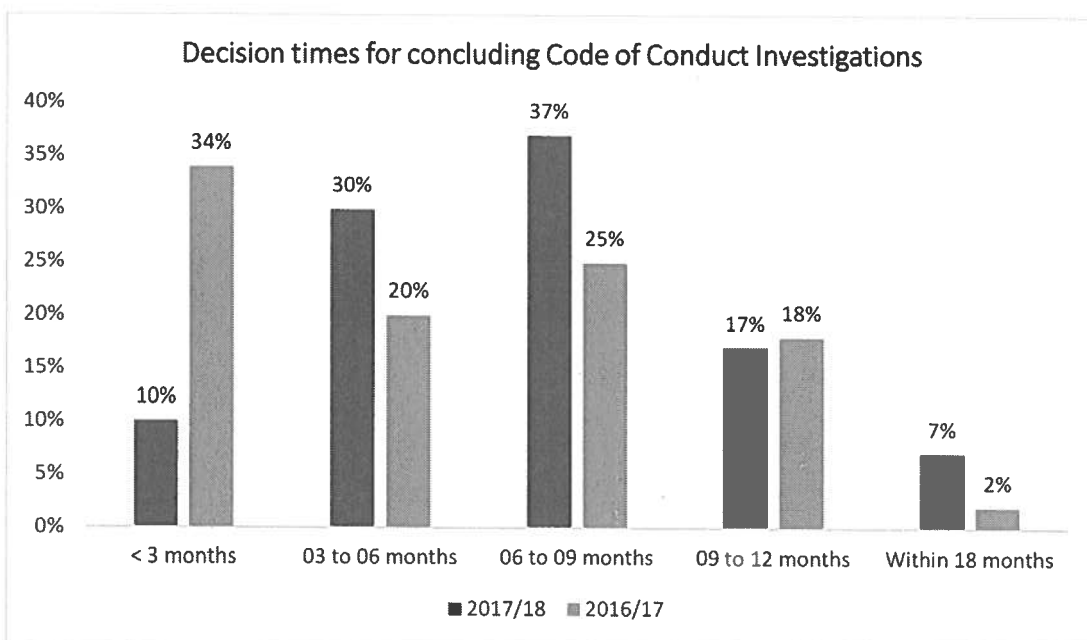
Graph 1.5

### Decision times for concluding Code of Conduct investigations

The overall number of decisions on Code of Conduct complaints in 2017/18 was similar to that in the previous year. However, due to the fact that the cases which require investigation are often complex, coupled with external factors beyond our control and the pressures of the “health heavy” investigation caseload, fewer cases were concluded within three months – 10% compared with 34% in 2016/17.

I recognise the implications of longer decision times in these cases, for the complainant, for the councillors complained about and for the wider public interest. I will continue to work to reach timely conclusions in these cases in the year ahead.

Graph 1.6 below shows decision times for Code of Conduct complaints for 2017/18 compared with 2016/17.



Graph 1.6

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## Cases of Note

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During 2017/18 I issued four public interest reports which generated considerable national interest. These can be found on my office's website [here](#)

Each of the public interest reports were health related - two concerned services at Betsi Cadwaladr University Health Board, one was about Cwm Taf University Health Board and one related to Hywel Dda University Health Board.

The cases included:

- A patient who died on a hospital trolley following shortfalls in the provision of end of life care and poor complaints handling. My investigator found that the patient's dignity had not been respected and she had not received sufficiently considerate end of life care. My office issued a number of recommendations, including that Betsi Cadwaladr UHB apologise and provide the complainant with financial redress of £1,500, refer the report to the Health Board's Equalities and Human Rights team, remind medical staff of their obligations for ethical and clinical management during end of life care, consider further staff training in end of life care and carry out a clinical audit of the wards involved in this case.
- A patient who suffered a cardiac arrest and died after staff failed to correctly diagnose and manage his heart failure. My office found that junior doctors had been inadequately supported, the patient's family had not been suitably advised and there were substantial delays in responding to the complaint. An apology and redress totalling £2,750 was secured for the complainant. A number of recommendations were also made, including that the Health Board produce a detailed escalation policy, remind medical staff of daily review recording procedures and their obligations to adequately support and supervise Junior Doctors, and review pre-operative assessment protocols.
- A Health Board that took more than three years to provide a final response to a complaint. I found evidence of maladministration, including misplaced records and communication failures, and a lack of transparency in investigating a complaint about a breach of duty of care. The Health Board agreed to make a total redress payment of £4,000, arrange free legal advice and independent clinical adviser for the complainant, and to remind all medical staff of their duty to be open and transparent with patients and families.

- Failure by medical staff to reach reasonable standards of care and treatment of a patient. Several opportunities to identify and prevent a patient's deterioration were missed leading to him suffering a fatal cardiac arrest. Furthermore, the complaint was poorly handled and an unreasonable length of time was taken to provide the complainant with a response. The Health Board agreed to a number of recommendations including an apology and a payment of £10,000 for the complainant, in recognition of the distress and uncertainty caused.

The last of these complaints was made by the patient's daughter, Ms C, who worked for Betsi Cadwaladr University Health Board handling complaints.

Commenting on this final report at the time, I said:

"I find it extremely concerning that the Health Board refuses to admit that, had they approached the patient's care differently, his death could have been prevented. Not only was the care substandard in this case, I find the Health Board comments disingenuous and indicate an unwillingness to accept the seriousness of the situation.

"The fact that a member of its own staff, accustomed to the concerns process, found the Health Board's approach to her complaint so frustrating that she was forced to seek assistance from an advocate, does not instil confidence for members of the public using the system."

Following our investigation, Ms C got in touch with my office.

She said:

*"Thank you once again for all you have done to bring my family and I some sense of closure but, most of all, the truth."*



## Annex B: Code of Conduct Complaints closed— Statistical Breakdown by outcomes by local authority

### County/County Borough Councils

County/County Borough Councils	C	D	NE	NA	SC	AP	W	Grand Total
Blaenau Gwent	3	1						4
Bridgend	3			1				4
Caerphilly	4							4
Cardiff	2		1					3
Carmarthenshire	6							6
Ceredigion	1							1
Swansea	6							6
Conwy	4			1		1		6
Denbighshire	2							2
Flintshire	3					1		4
Gwynedd	6		1					7
Isle of Anglesey	3							3
Merthyr Tydfil	6		1					7
Monmouthshire	3					1		4
Neath Port Talbot	1							1
Newport	3							3
Pembrokeshire	9							9
Powys	13		5	1				19
Rhondda Cynon Taf	1							1
Torfaen	4			2				6
Vale of Glamorgan	1		1					2
Wrexham	1							1
<b>Grand Total</b>	<b>85</b>	<b>1</b>	<b>9</b>	<b>5</b>	<b>0</b>	<b>3</b>	<b>0</b>	<b>103</b>

Key	
C	Closed after initial consideration
D	Discontinued
NE	No evidence of Breach
NA	No action necessary
SC	Refer to Standards Committee
AP	Refer to Adjudication Panel
W	Withdrawn



Community/Town Councils

Community/Town Council	C	D	NE	NA	SC	AP	W	Grand Total
Abertillery & Llanhilleth Community Council				1				1
Barmouth Town Council	1							1
Barry Town Council	3							3
Beaumaris Town Council	1							1
Bedlinog Community Council	2							2
Bishton Community Council	1							1
Brackla Community Council	3							3
Brawdy Community Council	3							3
Bridgend Town Council	1							1
Caerphilly Town Council	1							1
Chepstow Town Council	5							5
Clyro Community Council	10							10
Conwy Town Council	1							1
Cosheston Community Council	2							2
Cwmbran Community Council	1							1
Dinas Powys Community Council	1							1
Garw Valley Community Council	2	1						3
Glynneath Town Council	6	1					1	8
Gorseinon Town Council	2							2
Guilfield Community Council	4							4
Hirwaun & Penderyn Community Council	1						3	4
Johnston Community Council	9							9
Knighton Town Council	3							3
Langstone Community Council	2							2
Llanbedrog Community Council	3			2				5
Llanddowror and Llanmiloe Community Council	2							2
Llanelli Rural Council			1					1
Llanfechain Community Council	1							1
Llanfrynach Community Council	2							2
Llangefni Town Council	1							1
Llangristiolus Community Council	1							1
Llangybi Community Council (Monmouthshire)	2							2
Llanover Community Council	1							1
Llansannan Community Council	1		1					2

Community/Town Council	C	D	NE	NA	SC	AP	W	Grand Total
Llay Community Council	4			1				5
Magor with Undy Community Council	1							1
Milford Haven Town Council	1							1
Mold Town Council	2							2
Mumbles Community Council	3	1						4
Nantyglo & Blaina Town Council	1							1
Neath Town Council	1							1
New Quay Community Council	1							1
Northop Hall Community Council	4							4
Ogmore Valley Community Council	1							1
Pembrey & Burry Port Town Council	14							14
Pembroke Dock Town Council	1							1
Pencoed Town Council	1							1
Penmaenmawr Town Council	1							1
Pentyrch Community Council	1							1
Porthmadog Town Council	1							1
Prestatyn Town Council	2							2
Saltney Town Council				1				1
Sully and Lavernock Community Council	1							1
Taffs Well Community Council	2							2
Trawsgoed Community Council	1							1
Tywyn Town Council	1		2					3
Welshpool Town Council	1							1
Ynysawdre Community Council	3							3
<b>Grand Total</b>	<b>128</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>0</b>	<b>0</b>	<b>4</b>	<b>144</b>

**Key****C** Closed after initial consideration**D** Discontinued**NE** No evidence of Breach**NA** No action necessary**SC** Refer to Standards Committee**AP** Refer to Adjudication Panel**W** Withdrawn

**E. Code of Conduct Complaints Closed**

County/County Borough Councils	Closed after initial consideration	Discontinued	No evidence of Breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total
Vale of Glamorgan	1		1					2

**F. Town / Community council Code of Conduct Complaints**

Town/ Community Council	Closed after initial consideration	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total
Barry TC	3							3
Dinas Powys	1							1
Sully & Lavernock CC	1							1