Pecyn Dogfennau

Agenda

Pwyllgor Safonau

Dyddiad: Dydd Iau, 12 Ionawr 2023

Amser: 5.30 pm

Lleoliad: Ystafell Bwyllgor 1 / MS Teams

At: Cynghorwyr D Fouweather, F Hussain and P Cockeram. A Mitchell (Cadeirydd), Watkins (Dirprwy Gadeirydd), J. Davies, R. Morgan, P. Worthington and G. Nurton

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Eitem		Wardiau Dan Sylw
1	Ymddiheuriadau dros Absenoldeb	
2	Datganiadau o ddiddordeb	
3	Cofnodion y Cyfarfod Diwethaf *(Tudalennau 3 - 14)*	
4	Materion yn codi	
5	Cyhoeddiadau'r Cadeirydd Derbyn unrhyw gyhoeddiadau y mae'r Cadeirydd yn dymuno eu gwneud.	
6	Cwynion *(Tudalennau 15 - 20)* Bydd y Swyddog Monitro yn adrodd ar unrhyw gwynion a dderbyniwyd ers y cyfarfod diwethaf.	
7	Coflyfr Cydraddoldeb a Hawliau Dynol 2022-2023 *(Tudalennau 21 - 60)*	
8	PSOW Data Safonau Cwynion Ebrill i Medi 2022 *(Tudalennau 61 - 62)*	
9	Dyddiad y Cyfarfod Nesaf Dydd Iau, 12 Ebrill 5.30pm – 7pm Ystafell Bwyllgor 1	
10	Digwyddiad byw Click here to view the live event	

Person cyswllt: Emily Mayger, tîm llywodraethu
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Dyddiad cyhoeddi: 16th Ionawr 2023

Draft Minutes

Standards Committee

Date: 15th November 2022

Time: 5:30pm

Venue: Microsoft Teams Meeting

Present: A. Mitchell (Chair), K. Watkins (Vice Chair) J. Davies, P. Worthington, R. Morgan, G. Nurton, Councillors D. Fouweather, F. Hussain and P. Cockeram. Elizabeth Bryant (Head of Law and Regulation). Felicity Collins (Governance Officer) and Pamela Tasker (Governance Officer)

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1. **Apologies for Absence**

   Mr Richard Morgan sent his apologies.

2. **Declarations of Interest**

   No Declarations of Interest.

3. **Minutes of the Previous Meeting:**

   Mr Kerry Watkins noted that his apologies were not recorded in item 1 and asked for them to be included.

   The minutes of the meeting held on the 14th July 2022 were accepted as a

   true and accurate record.

4. **Matters Arising**

   No Matters Arising.

5. **Chairs Announcements**

   No Chairs Announcements.

6. Party Leaders Discussion

Invitees:
Councillor Jane Mudd – Leader of Newport Labour Party
Councillor Matthew Evans – Leader of Newport Conservative Party
Councillor Allan Morris – Leader of Independent Party Lliswerry
Councillor Kevin Whitehead – Leader of Newport Independent Party

The Chair expressed his concern to Councillor M. Evans that Councillor Fouweather is meant to be a Member on the Standards Committee and has not sat in a meeting as of yet.

Councillor Evans apologised for the absence of his peer.

The Party Leaders were welcomed by the Chair and Committee and were asked to confirm how they maintain the standards required from their political parties.

Councillor Jane Mudd – Leader of Newport City Council

The Leader explained that she has a dual role as Leader of the Council and Leader of the Labour Group. With regard to the role as Leader of the Council, the Leader explained she meets regularly with the Head of Law and Standards and Democratic Services Manager on a weekly basis to go through the training programme with informal discussions to address emerging issues and put measures in place.

The Leader used an example where she would like fellow elected Members to gain more confidence with IT which she felt would be important with standards not only in relation to the use of the equipment but also in terms of the language used by Members through email which has the potential to unintentionally offend others because of the tone.

The Leader reported that they are looking to address this issue. The Democratic Services Manager is going to introduce drop-in sessions with a more informal nature to discuss aspects that they may not feel confident about to encourage a better atmosphere.

The Leader then covered the group aspect as being Leader of Newport Labour. As with any political party, there are structures in place to implement group discipline. It is a part of Newport Labour's Councillor contract as they are committed to high standards. The structure includes a Party Whip is there for member support as well as other issues.

The Leader explained that as they have a vast number of Members, the new Members have been matched up with more experienced Members for support. The Leader explained that the party want their Councillors to be the best they possibly can for the communities they serve and recognised that they can face challenges on conduct.

Committee raised the following points:

• The Chair understood that parties try to limit reputational damage and asked how the party tries to limit its Members being in breach of their Code of Conduct. The Chair also asked if the party has policies in place for reputational damage or would the Members go to the Head of Law and Standards.

The Leader confirmed that in that in those circumstances, Party Members would go to the Head of Law and Standards for guidance but explained that informal processes are in place before any formal actions are taken. The Local Resolution process is very successful. Important to maintain dialogue and support people. The Leader commended the Head of Law and Standards for being helpful with that.

• Mrs Nurton referred to the attendance list and mentioned that 37 out of the 51 Members completed the ethical standards training and asked the Leader what she is doing to encourage all Members to undertake the training.

The Leader explained that they have a reporting structure in which the Democratic Services Manager is able to report back to the group business managers. As training took place early on straight after the election, a lot of Members were away after the campaign. The Leader ensured that they will follow up with a session to ensure as many Members as possible able to attend. The Leader noted her confidence in the reporting process and mechanisms enable us to identify training attendance.

• Councillor Cockeram commented that he is mindful of the meetings being broadcast, such the pre-meeting chat in the 15 minutes prior to the meeting. Those participating are responsible for those discussions before the recording of the meetings start. The Member believed that all political groups need to be aware of that as it happened at the last full council meeting.

• Mr Watkins noted the mention of informal meetings with colleagues and asked if any of the meetings have been recorded in a formal manner and put in annual reports.

The Leader confirmed that as the Leader, she meets with the Democratic Services Manager and Head of Law and Standards regularly as part of the Cabinet Member Briefing programme with the Democratic Services having oversight of the internal process. The formal minutes are taken in the same way as a public meeting and the records of discussion are kept. The Member advised she could come back to those if the Committee would like them.

The Leader also mentioned the electronic system that the council has which records Members' attendance, this is a huge advantage as it enables the team to download and access that information quickly.

The Chair raised whether in future group leaders would be required to provide something in writing or invite them to meetings to see how things are going. Although next committee meeting is in January Chair suggested all standards training signed off by the second meeting in the New Year.

Following on the conversation, Councillor Evans added that if someone has not attended a meeting, it would be useful if he could be notified of that.

Councillor Matthew Evans - the Opposition Leader (Newport Conservatives)

Councillor Evans introduced himself to the Committee and explained that the Party has two new Councillors and that five of the seven are longstanding. They also have a buddy system in place like Labour Group for support to meet informally and chat things through.

The Members are all signed up to the Conservative Councillor Association and abide by the party rules. All have gone through the selection process and are selected independently. They are offered opportunities for external and internal training.

The Opposition Leader went on to highlight that he has recently worked with officers for a local resolution as a Member of the group was abrupt in email correspondence. It was explained that this has been resolved as they have met with the Head of Law and Standards and Chief Whip.

Councillor Evans also mentioned that he has meetings with the Leader on a regular basis, talks to the independent party groups on a need to know basis, and stated that they all signed up to the Code of Conduct at the May Election. As far as the mandatory training goes, we need to attend the training and set an example for all.

Committee raised the following points:

- Dr Worthington thanked Councillor Evans for his introduction and expressed his interest in the notion of buddying the newly Elected Members with longstanding ones. It is important that Members buddying up are fully signed up to the notion of the ethical standards and asked if that culture trickles down.

Councillor Evans mentioned that they have long standing Councillors and that it is important when you have any new Members just as taking on any trainee/apprentice in work that they do not get into any bad habits. Some of the Members of the Newport Conservative Party are long standing business people and Councillor Evans stressed that being a Councillor means having various roles to undertake, and that the Members are aware of their obligations and of his as Party Leader to them.

Councillor Allan Morris – Leader of the Lliswerry Independent Party

Councillor Morris introduced himself to the Committee and noted that his party is the smallest group with two other Members who are very sensible as independents and are reluctant to get involved in things that are beyond their Lliswerry ward. They have a meeting once a month and see Councillor Morris as a mentor, although he admitted that he has not had the training and would be more than happy to undertake any training sessions necessary.

The Chair thanked the Leaders for their introduction and time and asked the Leaders for their feedback on the pro-forma in the report pack. The Chair asked for consideration of whether the Leaders provide verbal feedback for the committee or use the pro-forma.

Party Leader Comments in relation to the pro-forma

- The Leader of the Council pointed out that it refers to a few things as group leaders, with references to complaints to the ombudsman. The Leader highlighted that they are completely confidential. If the Members would find it helpful to provide

the Leaders with a guide on what they would like to feedback to them on, the Leader said she was happy to do that. The Leader felt that it would be helpful to have feedback in person as happened today.

- Councillor Evans agreed with Leader to ensure that Members receive the mandatory training for sitting on a committee. As those Councillors sitting on planning and licensing cannot sit in the meetings before they have the training. Member was happy to attend every meeting if necessary but commented that would be more of a tick box exercise.

The Chair thanked all of the Party Leaders for their comments and time and stated it is good to have a chance to meet to discuss how they can work together to ensure that council colleagues and the council reputation is kept safe.

Mr Watkins suggested that a simple annual written report would be essential for the committee to have a record of what has been obtained, and perhaps have a combination with personal interaction to ensure it is satisfactory for all. The Committee Member stated he liked the idea of building the reputation between the party leaders and the committee.

The Chair added that it could be added as the first item on the agenda annually with a short report from the Leaders.

- Mrs Nurton stated that she would prefer regular dialogue with the Leaders and expressed her disappointment that the Committee will have to wait for another two meetings for the Members to complete their training. It was suggested that perhaps those who have not undertaken the training may be long standing Councillors who are already aware of the required standards.

The Chair and Committee agreed that a personal visit biannually would be ideal and to try to receive reports through email from the Leaders.

- Mr Watkins felt that bi-annual meetings would be helpful and that at the end of the year would need something in writing they could know where they stand with training and the ethics involved with the training.

- Mr Davies would like the committee to keep a record of training attendance; and ask the Members to attend and ask why it has not been carried out as Members should be doing it and suggested to look at next April for another meeting.

- Dr. Worthington agreed with the prior point that an audit written trail is important for good governance with a mix of personal visits and written reporting sounds right. Agree not able to tick of 100% at this stage.

- The Committee agreed to invite the Party Leaders back to their April meeting to have an update on their training and other points to cover. The Chair suggested they could invite the leaders to provide a report beforehand on which way the discussion is likely to go, such as a brief of anything that has happened. Chair asked colleagues in Democratic Services to invite the leaders to the April meeting.

- Councillor Cockeram felt it was important to note that the focus is not just about training but also it should set down what they expect from the Leaders. In his

new role as Presiding Member as a longstanding Councillor, he is aware that some Members do not show up to meetings and there is a need to focus on absenteeism rates. Previously needed to explain why not attending meetings. It was suggested that the Standards Committee should set standards for Leaders to confirm their absenteeism rates. Suggested discussing absenteeism of meetings at Standards Committee.

- Councillor Hussain agreed with that notion and stated that Councillors need to be responsible with their role and that they should be notified of absence with an explanation.

The Head of Law and Standards reminded Members that Councillor Attendance is not a code of conduct issue, but behaviour is and that they monitor that. The Councillor Attendance records are published on the website and if they do not attend any meetings within 6 months then they are automatically disqualified. The Democratic Services team keep an active record and assured the Members that they take the point raised but reiterated that it is not about ethical standards. Similar to complaints to the ombudsman where constituents feel they are not represented much by their councillor which is a matter for voter choice. The Head of Service explained that whilst non-attendance may not look good in a representational role, but it is not something the Council can monitor with code of conduct.

- The Chair referred to the pro-forma leaders report form presented to the Committee, as it was mentioned by Councillor Mudd some parts may not be relevant to the council.

The Head of Law and Standards informed the Members that they are not wedded to the document as it came from Denbighshire Council as an example of some of the questions that might stimulate discussion in the committee meeting.

Agreed that some of the information in terms of numbers of complaints shouldn't be included. It was explained a later item in the meeting covers an update on complaints, presented in a schedule anonymously. The monitoring officer saw no reason why they cannot be shared with the group leaders anonymously, so they can be aware of ongoing complaints raised against Councillors.

The Head of Law highlighted in terms of the approach, the guidance advises that the Committee would need to receive a report from the group Leaders at least once a year which could be either a verbal or written report. And that it is up to the Committee if they would like to meet up with them more frequently should issues arise in the year to deal with specific items in the group or conduct issues.

- The Committee expressed an interest to invite the Leaders back in 6 months' time in order to review their training records and the Officer advised that the committee could defer any written reports after that meeting to see if any specific issues to include.

It was explained that it is important to not make the report too onerous for the Leaders and on reflection of the training record for Code of Conduct training; Democratic Services has only done one training session on 16 May 2022. There are another 16 Members that need to be trained therefore it was acknowledged that the Council needs to arrange mop up sessions for that training in the New Year. The

Monitoring Officer recognised that there is more that the council can do to help the Members attend the sessions. It was mentioned that the slides from the training sessions are available for the Members on a shared microsoft teams folder. Therefore, the Members have access to the materials from the training. It is possible that some in their own time may have brushed up on their knowledge, but the team is conscious of the need to arrange some more training session in the New Year before April and advised that they can report back next time on that.

- Mrs Nurton asked if the Members have the opportunity to do training on e-learning.

The Head of Law and Standards highlighted that the only issue with that is method is that they would need to create an e-learning module with questions. At the moment the information in the shared folder are the presentation slides and the information. Preference at the moment would be some further training sessions which can be remotely. The team could look into developing a training module with IT in order to be interactive, but this option will be kept in reserve pending how many members attend the training.

- Mrs Nurton commented that hopefully the National Monitoring Officers Forum would be in place by then and we can share best practice with other Monitoring Officers.

- The Committee Members agreed to invite the Party Leaders back to the Committee in April to finish off 22/23 and then come to some agreement as to how it will be presented to the Committee from there.

7. Whistle-blowing Policy

The Head of Law and Standards asked the Committee Members to consider the updated policy and review its' effectiveness. It was highlighted how they can have an overlap with ethical standards, behaviour and misconduct in public office. The Monitoring Officer explained that every council must have a policy and up to the committee to look at the revised policy and how effective the committee thinks it is in terms of implementation. It explained that the updated policy is on the intranet for all staff and that a communication went out in September with a link to the new policy with a mandatory e-training module. It was pointed out that around 500 members of staff have undertaken the training so far.

Just a question of whether Committee are happy with what has been done with policy and how that has been rolled out to staff.

As background, the Committee was also provided with information on the figures of whistle blower complaints over the last 12 months. Newport had around 5 complaints over the period, which is average according to the table with Rhondda Cynon Taf Council at the top with 18. None of NCC's complaints were upheld, they were more minor disciplinary matters which were dealt with internally. Two of the five issues have not been upheld and the other three involved staff leaving before action could be taken against them. There is one issue outstanding complaint in relation to TTP funding which is still being investigated by the internal auditor and will be reported in next year's figures. Currently not concerns in relation to the complaints

The MO asked the committee to confirm whether they are happy with the information they have been provided with or whether they need more information.

- Councillor Davies asked who would primarily investigate the complaint and who can access the on-line training module.

The Head of Service advised that the nature of the allegation influences who would need to investigate it. Disciplinary matters would be dealt with under certain disciplinary codes, where the relevant line manager or Head of Service would deal with the investigation. If it were serious financial fraud, then that would be a police matter. If it involved an external agency dealt with on a different basis. If it was a safeguarding complaint would go through the council's safeguarding processes. The training is available to all staff only. It is an internal training policy for staff because the policy applies to council staff.

- The Chair explained that because the policy has been put together by officers, we would normally accept this, but this is slightly different.

- Mr Watkins confirmed he was content with the report and liked the breakdown of where Newport stands with other councils, and that the outcomes of the five complaints mentioned was essential.

- The Committee confirmed that they are content with the policy as it is. It was agreed that the committee would receive an annual report on whistleblowing complaints figures.

8. Terms of Reference

The Committee was advised that the document came from the National Standards Conference for information. It was highlighted that there was a feeling that regular meetings on an all Wales basis with the Chairs of Standards would be helpful.

This was drafted by the Monitoring Officers Forum with a terms of reference for comment and information. There was a suggestion that the Group will comprise chairs of all 21 Council's committees and the Deputy can attend once a year and the chairing of the group to be rotated every 2 years. The Ombudsman is keen to attend and establish a dialogue so we would encourage Standards Committee participate in that. There's 21 Monitoring Officers, suggestion that one MO from each region attends by agreement and to rotate it to share it. If the Committee has any suggestions then they could feed it back.

- Dr. Worthington asked for the definition of the region, to which the Lead Officer advised Gwent. Dr. Worthington went on to ask if that covers four regions across Wales.

The Head of Law and Standards explained that it is a footprint, as an extended city region. Mainly areas such as Gwent, Cardiff, Bridgend, West Wales. Advised that there are groups within those groups. It was agreed amongst the Monitoring Officers that the chair of each committee is required. The Monitoring Officers meet to discuss

legal interest on a quarterly basis and that this is more for the benefit of the Chairs of the Standard Committees.

• Councillor Cockeram asked if the chairs of all of the Standards Committees have an input on how to change guidelines or recommendations to make changes. For example, the Member commented that it is good to see the compliments as well as complaints.

The Head of Law and Standards explained with the idea about the forum, the collective force in terms of opinion can influence the ombudsman, WLGA and Welsh Government. In the conference, the Richard Penn report was mentioned with an independent review of the ethics standards in Wales. A number of recommendations are outstanding as the Welsh Government are yet to adopt them.

It was explained that the informal motion passed to encourage Welsh Government to make those reforms and this forum could go back to WG as lobby the group with a power to make change the Code of Conduct matters for example those that Richard Penn report recommended for change in ethical standards, but not issues such as councillor attendance.
The Committee noted the content of the report and agreed to wait for the first meeting to be convened.

9. Ombudsman Annual Report 21/22

Head of Law and Standards advised the link is attached to the report and that it is in two parts, maladministration complaints about council, which are less of a concern for Standards Committee and more concerned for the Code of Conduct complaints.

Similar report to governance and audit committee, where it would be a report not just on complaints from the ombudsman but from customer services, including the compliments also.

The Head of Law and Standards gave a breakdown of the percentage of the maladministration complaints whereby the numbers increased after the lull from the pandemic. Newport had 40 complaints in 21/22, which saw an increase of 29% compared with the previous year. 4 of which resulted in intervention from the Ombudsman. From a maladministration complaints perspective, there were no serious findings or public reports of maladministration during that period.

Members were signposted to paragraph 5 which shows that although complaints to the Council have increased by 37%. However, we do log compliments, 208 were received, so it is a fairly balanced response of council services. It was noted that 96% of complaints were dealt with internally so did not go to the Ombudsman. The Ombudsman is more concerned with how the complaints are resolved rather than numbers.

The Committee was informed that with the Code of Conduct complaints across Wales, that 294 new complaints were about Member misconduct which is a 5% reduction from last year. As a caveat to that in the previous year the numbers had gone up rapidly so it is still much higher than previous years.

The main concern for the Ombudsman was that the seriousness of complaints had increased. Over 50% failure to show consideration and respect and breaches of equality and can be more serious in terms of bullying and harassment. This is for the financial year 21/22 so not the same as standards committee November to November year.

In terms of the conclusions of what the Ombudsman would like to see in terms of improvements including training sessions being high on the agenda for all Councillors to improve conduct issues.

The Committee thanked the officer for the presentation and report.

10. Standards Committee Annual Report

The Head of Law and Standards appreciated that the annual report has come early to Committee as the council meeting is taking place on 22 November with the agenda being published tomorrow. Due to the timing, the officers have had to put the draft report forward this evening which is a summary of the work of the committee from the last 12 months as a statutory report as you now have duty to report annually, including reference to discussions with group leaders.

Committee was advised that usually a Councillor that sits on the committee would volunteer to present it to full council.

Councillor Cockeram agreed to present it in the Full Council meeting as Presiding Member.

- Mrs Nurton asked for a point of accuracy on the training numbers provided as it stated that 34 were remote, and 10 present and asked we can check that.

The Head of Service confirmed that they were about to correct that and that those figures are wrong and assured the committee they will rectify the numbers for the final report. On their record, they have 35 in total, with 4 in person and the rest remote.

- Dr. Worthington commented that he assumed the report would be moving to financial reporting as opposed to November to November.

The Head of Service explained that is a matter for the Committee as it is important that they had a chance to meet with the party group Leaders and that it is entirely up to the Members if they would like to align the meetings to the financial year. November was the earliest the Council could do since the May elections due to the reporting cycle. If the Committee wish to change it to financial year reporting after April, they can do that and aim to get it to the Councill meeting in July as Council meetings take place every 6 weeks. Would need to fit into the Council work programme.

- Dr. Worthington noted he appreciated the work that has gone into it and expressed his concern that he did not wish to put an onus on staff for the period to be either November or financial year and that he has no strong views on that.

- Mrs Nurton noted that Council agendas can be quite full in July and suggested that if they would stick to the November cycle so that it gets due consideration but welcomed officer input on that point.

The Head of Service noted that the Council do not receive the ombudsman report until September anyway as the next council is November, so it would not be that much out of sync should the Committee prefer to stick to the November cycle. The Committee considered the points raised in the discussion and agreed to leave the cycle as it stands in November.

11. Complaints Update

The Head of Law and Standards advised that the report is made as a written record going forward and as mentioned earlier we can share this information with group leaders so that they are aware of any ongoing complaints, and explained that they kept them anonymous as the individuals mentioned could be easily identified. It was highlighted that the outcomes are recorded and therefore suggested that in future, for reporting that this format could be used as a running log of complaints and suggested that the Committee could add it in to make a composite list.

- Councillor Davies commented that he could not see much on the complaints about Bishton Community Council and asked if that fell in the previous year.

The Head of Law and Standards confirmed that it was due to that reason and that the schedule contained ones that are ongoing. Therefore, they started afresh this year and will look to add to it.

- Councillor Davies noted how the ombudsman took 18 months to deal with the complaint.

The Head of Law and Standards informed the Committee that ombudsman complaints can take 12 months to be dealt with, it was mentioned that one in the schedule may go back further than that as the investigations take a significant period of time.

The letter from the ombudsman included in the report is to be read in conjunction with the report as they are piloting a new triage system in terms of complaints. This is where they look at complaints first and decide whether they need to investigate before they notify the relevant Monitoring Officer and Councillor. Prior to the system, it could be spurious where they had to notify the Monitoring Officer and Councillor and the Councillor would be invited to comment on it. The triage system would filter out some of the complaints and inform them of the outcome.

- Councillor Cockeram queried as he is on the Standards Committee, he asked for clarity on where he would stand on a hearing sitting if a complaint was made about a Councillor in the same political group.

In response, the Head of Service informed the Councillor that it is entirely up to him. The Member was advised that if the Councillor was a close personal friend; then he would have to declare an interest and stand down. It was noted that being in the same political party does not disqualify someone from sitting in judgement and

conducting a hearing. The issues is whether you can be seen as fair and unbiased. If the member was a close personal friend, you would probably excuse yourself from the hearing but that is a personal choice and judgement. You want a balanced panel of elected and independent members.

12. Date of Next Meeting:

Thursday 12th January 2023, 5.30pm – Committee Room 1

The Chair and Committee wished to take a chance to thank the Head of Law and Standards for all of his support over the years and wished him a long and happy retirement.

The Head of Service expressed his thanks to the Members for their support along the years.

Report

Standards Committee

Part 1

Date: 12 January 2023

Subject **Complaints Update**

Purpose To update Standards Committee on Code of Conduct complaints made to the Ombudsman.

Author Head of Law & Standards

Ward General

Summary The report provides an update of complaints made to the Ombudsman about City and Community Councillors, the nature of the complaints and the outcomes.

Proposal **To note the report.**

Action by Head of Law & Standards

Timetable Immediate

Background

1. All complains made to the Public Services Ombudsman for Wales about alleged breaches of the Members Code on Conduct by City and Community councillors are reported to Standards Committee for information.

2. Where the Ombudsman has decided not to accept the complaints for investigation or they are still under investigation, then they are reported on a strictly confidential and anonymised basis and neither the identity of the member nor the complainant is disclosed.

3. However, details of the allegations, the nature of the complaints and the outcomes, including the reasons for the Ombudsman's decision, are all reported to Committee, for information purposes and to identify any specific areas of concern or matters that may require further clarification or training.

4. The attached Schedule sets out those complaints that have been submitted to the Ombudsman since the last meeting, together with details of complaints still under investigation.

Financial Summary

There are no financial implications

Risks

Risk Title / Description	**Risk Impact score of Risk if it occurs* (1-5)**	**Risk Probability of risk occurring (1-5)**	**Risk Mitigation Action(s)** What is the Council doing or what has it done to avoid the risk or reduce its effect?	**Risk Owner** Officer(s) responsible for dealing with the risk?
Failure to receive regular updates on numbers of complaints and their outcome will reduce the effectiveness of the Committee's role in improving ethical standards	3	1	Receiving regular updates and reviewing the outcome of the cases will enable the Committee to take a more effective role in improving ethical standards.	Head of Law & Standards and Assistant Head of Legal Services

*Taking account of proposed mitigation measures.

Links to Council Policies and Priorities

The underlying Nolan principles are all enshrined in the Council's corporate and well-being objectives.

Proposed action

To note the report.

Comments of Chief Financial Officer

There are no financial implications

Comments of Monitoring Officer

Set out in the Report.

Comments of Head of People Policy & Transformation

There are no specific staffing or policy implications

Fairness and Equality Impact Assessment:

- **Wellbeing of Future Generation (Wales) Act**
- **Equality Act 2010**
- **Socio-economic Duty**
- **Welsh Language (Wales) Measure 2011**

No FEIA is required, as the Committee are just receiving this report for information.

- There are no negative impacts in terms of equalities or social disadvantage.

- In terms of the sustainable development principle and 5 ways of working

  Long-term – The complaints update will assist Standards Committee in taking a long-term view about ethical standards
  Prevention – The complaints update will help to prevent future complaints
  Integration – The complaints update has been prepared on the basis of information provided by the Ombudsman's office
  Collaboration – The complaints update should facilitate the resolution of complaints, in a more collaborative way.
  Involvement – The complaints update will facilitate greater involvement on the part of Standards Committee in identifying and addressing any trends or issues.

Background Papers

Confidential correspondence with the Ombudsman's office regarding individual complaints.

Dated: 5th January 2023

CODE OF CONDUCT COMPLAINTS

PSOW Reference	Council	Complainant	Alleged breach of the Code	Outcome
2021/06820	Newport City	Corporate	Criminal conviction of a former City Councillor, which brought his office and the Council into disrepute.	Still under investigation
2022/10227	Newport City	Councillor	Complaint regarding an offensive private Facebook post during the pre-election period, in breach of equalities and duty to show respect and consideration for others	PSOW did not find any evidence of a breach. The post was made in a private capacity, so the only potential breach was in relation to bringing the office of Councillor into disrepute. PSOW felt that the comment may have offended some people but it came within the Councillor's Article 10 rights to freedom of expression.
2022/02284	Newport City	Public	Failure to respond to constituent's concerns about homelessness and begging in the City Centre	PSOW did not find any evidence of a breach. The Code did not require members to respond to constituents. That was a matter for the ballot box.
2022/02545	Newport City	Public	Alleged defamatory posts on a community Facebook page, which the Councillor had failed to remove. Breach of equalities duty, failure to show respect and consideration and bringing office into disrepute	PSOW did not find any evidence of breaches of the Code and, in any event, did not consider it in the public interest to intervene. The Councillor was not required to either remove the offending posts or

				disassociate herself from them. She could not be personally liable for other people's comments. But they were removed from the site quickly, in any event.
2022/02641	Langstone community	Councillor	Alleged disrespectful and bullying behaviour towards the Clerk and other community councillors	PSOW found no evidence of any breach. The Councillor was entitled to make a complaint against the Clerk and to complain about other Councillors criticising his attendance record. This did not amount to bullying or disrespectful conduct.
2022/03726	Newport City	Public	Refusal to take up objection to planning application on behalf of the complainant because of declared friendship with applicant. Alleged conflict of interest.	PSOW did not find any breach. The Councillor had properly declared a personal interest in the planning application because of the close association with the applicant. The complainant could have objected in person or asked another ward Councillor to speak on her behalf at Planning Committee
2022/04331	Langstone Community	Public	Alleged failure to show respect and consideration to another community councillor.	PSOW did not find any breach. There was no failure to show respect and councillors need to have "thicker skins" when it comes to personal criticism. Councillors do not have to agree with one another and they can be robust in their disagreement, provided that their

				language is not gratuitously offensive.
2022/06378	Newport City	Public	Alleged failure to respond to telephone calls made by the complainant and their support work.	The PSOW did not find any evidence of a breach. The behaviour complained of was unlikely to amount to a breach of the Code. Whilst the behaviour complained of was discourteous it was more likely to relate to the members competency in their role which is a matter for the local electorate to determine through the democratic process.

Ombwdsmon
Ombudsman
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU
PUBLIC SERVICES OMBUDSMAN FOR WALES

Equality & Human Rights Casebook 2022/23

November 2022

We can provide a summary of this document in accessible formats, including Braille, large print and Easy Read.
To request, please contact us:

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Mae'r ddogfen hon hefyd ar gael yn y Gymraeg.

This document is also available in Welsh.

Ombwdsmon
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OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU
PUBLIC SERVICES OMBUDSMAN FOR WALES

Equality & Human Rights Casebook 2022/23

Contents

Foreword

This is our fourth Equality and Human Rights Casebook.

Much has changed since we first launched this publication in 2020, with the COVID-19 pandemic severely disrupting public service delivery in Wales, in the UK and around the world. However, our approach to equality and human rights issues that we see in our casework has remained unchanged.

We have always been clear that it is not our role to conclude that someone's human rights have been breached, or that they have been discriminated against. That is a matter for the Courts. However, we see in our casework every day that human rights and equality issues are often inseparable from people being treated unfairly and suffering injustice.

Therefore, if we see that someone's human rights or equality rights may have been engaged in the cases that we consider, we will state that clearly in our conclusions and make appropriate recommendations.

In 2021/22, we considered human rights and equality issues in 59 such cases. We hope that the selection presented in this casebook will help to continue to raise awareness of how we approach human rights and equality issues in our casework.

Many of the complaints that we considered in 2021/22 related to events that unfolded during the COVID-19 pandemic and during the measures and restrictions introduced to protect public health. Several cases in this casebook relate directly to such issues. Continuing the theme introduced in our previous Equality and Human Rights Casebook, we present here 3 cases related to the application of the 'Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)' procedure. We also include one case related to the rules around face-covering exemptions.

In addition, we include several cases in which we decided that the equality

duties of public service providers may have been engaged. The selection in this casebook focuses mainly on issues around offering reasonable adjustments to disabled people.

Although in most of the cases included in this casebook we upheld the elements of the complaint engaging human rights or equality issues, we also include several complaints that we did not uphold. We believe that this is important to better explain our approach to such cases, as well as to highlight correct administrative practice by the bodies investigated.

This publication focuses on our complaints about public services. However, I would like to take this opportunity to underline that we also embed attention to equality and human rights considerations in our other work.

Last year, we issued our first Own Initiative investigation report, 'Homelessness Reviewed', which raised important human rights and equality issues. The local authorities we investigated - Cardiff, Carmarthenshire and Wrexham - have worked hard to improve services to comply with our recommendations. That included actions to deliver equality and human rights training to homelessness staff and to make their homelessness services more accessible to service users. We continue to work with the 19 authorities that we did not investigate, monitoring progress and improvement throughout Wales to ensure improved services for those who are homeless or at risk of homelessness.

In addition, when we handle complaints about possible breaches of the Code of Conduct we also look at equality issues. Under the Code, councillors must respect equality of opportunity for all people. During 2021/22, we investigated some cases where that part of the Code was breached. For example, in one such case the councillor breached the Code by making comments about another member's hearing impairment and deliberately making it difficult for that member to participate in Council meetings.

We know that there is an ongoing discussion at UK level about the future of the Human Rights Act 1998. We are clear that, regardless of the outcome of those discussions. we will continue to do all we can to promote and protect the human rights and equality rights of the people who use Welsh public services.

Michelle Morris
Public Services
Ombudsman for Wales

November 2022

Background

About us

We serve the people of Wales in 3 different ways.

Our first role is to handle complaints about maladministration, service failure, or failure to provide a service by most public service providers in Wales, such as:

Local Government

NHS (including GPs and dentists)

Registered Social Landlords

Welsh Goverment and its sponsored bodies

More information on our process for handling complaints about public bodies in Wales can be found **on our website** (also in **Easy Read**).

Our second role is to consider complaints that elected members of local authorities have breached their Code of Conduct, which set out the recognised principles of behaviour that members should follow in public life. In this role, we can consider complaints about:

County and County Borough Councils

Community Councils

Fire Authorities

National Park Authorities

More information on our process for handling complaints about a local authority member's conduct can be found **on our website** (also in **Easy Read**).

Our third role is to drive systemic improvement of public services. Traditionally, we have done this mainly by publicising our findings, for example in public interest and thematic reports, annual letters to bodies in our jurisdiction and casebooks. However, in 2019 we were given new powers to drive systemic improvement. We can now undertake investigations on our own initiative, even when we have not received a complaint. We can also set complaints standards for public bodies in Wales and monitor their performance in complaint handling.

Equality and human rights frameworks

We are committed to the statutory principles and duties under the equality and human rights UK legislation and international frameworks. In looking at our complaints, we consider:

- the equality duties under the Equality Act 2010
- the Articles of the European Convention on Human Rights (ECHR) as enshrined in law by the Human Rights Act 1998 (HRA)
- the FREDA principles (Fairness, Respect, Equality, Dignity and Autonomy) – core values which underpin human rights.

Equality duties

The Equality Act 2010 introduced a **public sector equality duty** (the 'general duty'), replacing the separate duties on race, disability and gender equality.

Under the general duty we must have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct that is prohibited by the Act
- advance equality of opportunity between people who share a relevant protected characteristic and those who do not
- foster good relations between people who share a protected characteristic and those who do not.

The general duty covers the following protected characteristics:

- age
- disability
- sex
- sexual orientation
- gender reassignment
- race (including ethnic or national origin, colour or nationality)
- religion or belief (including lack of belief)
- pregnancy and maternity
- marriage and civil partnership (but only in respect of the requirement to have due regard to the need to eliminate discrimination).

Public bodies in Wales also have **specific duties** to help them in their performance of the general duty.

Under the Equality Act, service providers must provide **reasonable adjustments** to disabled people.

The cases included in this casebook relate predominantly to the protected characteristic of disability and provision of reasonable adjustments.

Providing reasonable adjustments means that organisations must take positive steps to remove the barriers people face because of their disability.

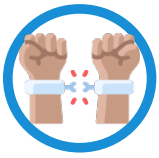
Human rights

The Human Rights Act 1998 incorporates into domestic UK law the rights and freedoms as set out in the ECHR.

Some are **absolute** rights, meaning that the citizen should be free to enjoy them, and the state can never interfere with that. There are some **limited** rights, meaning they might be interfered with in certain circumstances (such as times of war or emergency). Finally, others are **qualified** rights, meaning that the state can legally interfere with them in certain situations – for example, to protect the rights of other citizens.

The most common rights featured in the complaints considered by our office are the following:

Article 2 - The right to life



Article 3 - The right to be free from torture or cruel, inhuman or degrading treatment or punishment

Article 5 - The right to liberty and security

Article 6 - The right to a fair hearing

Article 8 - The right to respect for private and family life, home and correspondence

Article 9 - The right to freedom of thought, conscience and religion

Article 10 - The right to freedom of expression

Article 14 - The prohibition of discrimination

The cases included in this casebook engaged predominantly **Articles 2, 8 and 14.** We include more details about the scope of these articles **in the Appendix.**

Glossary

When we consider a complaint and find that something has gone wrong with public services, we can intervene at assessment stage or at investigation stage.

When we intervene at assessment stage, we call that an **Early Resolution**. This means we can make recommendations to public service providers faster, without conducting a full investigation.

If we need to conduct a full investigation and we find that something has gone wrong, we usually prepare a report or decision letter which explains our findings. Sometimes, we decide to issue a **'public interest' report**. We do this for example when:

- there are wider lessons from our investigation for other bodies
- what went wrong was very significant
- the problem that we found may be affecting many people, not just the person who complained to us, or
- we had pointed out the problem to the body in the past, but the body did not address it.

Otherwise, we usually publish the findings of our investigation as a **'non-public interest' report**.

The cases

In this section, we present some of the relevant cases that we closed during 2021/22. For this casebook, we have simplified and adjusted case summaries to make them more accessible and better explain the equality or human rights implications of the complaint. However, formal summaries of these cases can be found on our website **here**.

Cases about Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision means that if your heart or breathing stops, the healthcare team will not try to restart them. The decision should weigh up the potential benefits of resuscitation with the risk of harm to the individual patient. During the COVID-19 pandemic, the Welsh Government and the NHS placed restrictions on hospital visiting by patients' families and on funeral arrangements and social gatherings. They also amended the DNACPR policy and the guidance on the completion of death certificates. Most of these temporary provisions expired in March 2022.

202006132

Betsi Cadwaladr University Health Board

Non-public interest report

Health

Mrs A complained about care and treatment that her late husband, Mr A, received following his admission to hospital in April 2020. Mr A, who was 81 and had several underlying health conditions, was admitted with a sudden difficulty in breathing and shortness of breath.

Mrs A complained that the Health Board did not seek informed consent (from Mr A or her) before it put in place a DNACPR form. She also said that Mr A was not given correct levels of supplemental oxygen to help with his breathing.

In addition, Mrs A complained that the Health Board incorrectly certified that the cause of death included COVID-19 pneumonia, even though Mr A had tested negative. Mrs A argued that because the Health Board stated that her husband had COVID-19, she was not allowed to be with him when he died or view his body in the chapel of rest.

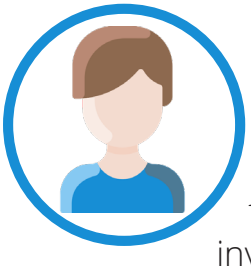
Finally, Mrs A said that undertakers were not able to prepare the body and so Mr A did not have the funeral he deserved. She was later told that his belongings had been disposed of on the day he died because of the infection risk and they were not returned to the family.

What we found

We did not uphold some aspects of Mrs A's complaint. For example, we did not see evidence that the clinical decisions taken during Mr A's care were inappropriate. We were also clear that a DNACPR decision is a clinical one, and the views of Mr A and his family would not determine how it was enacted.

However, we were concerned about how the medical staff communicated with Mr and Mrs A and how they documented their decisions. Because of the poor communication and record of the decisions when enacting the DNACPR procedure, Mr A's death was more distressing for his family.

In addition, because of poor communication, Mrs A was not aware of the extent of Mr A's decline and had not expected that her visit was the last time she would likely see her husband. The Health Board did not communicate clearly what would happen to Mr A's belongings, which further contributed to Mrs A's distress.



What our Investigation Officer said

Because of contrary evidence and poor record keeping around the DNACPR decision, we could not be sure that Mr A and his family knew that a DNACPR procedure had been enacted or were involved in the decision-making process.

If the communication and record keeping were better, the family would have had much needed assurance that the clinicians considered Mr A's wishes. In our view, the situation engaged **Article 8** of the Human Rights Act, which requires the Health Board to ensure that patients can express their wishes about what care and treatment they want to receive.

What we recommended

In addition to an apology and financial redress to Mrs A, the Health Board agreed to share our report with the relevant staff, to make sure that the communication and record keeping failings that we identified would not be repeated.

202004779

Betsi Cadwaladr University Health Board

and a GP Surgery managed by the Health Board

Non-public interest report

Health

Mrs B complained about the dosage of pain medication prescribed by the GP Surgery for her late father, Mr C, and about how this medication was managed. Mrs B also complained about the management and care that Mr C received when admitted to hospital with suspected bowel obstruction ("SBO"). In addition, she said that the Health Board did not communicate well enough with her and did not handle her complaint as it should have.

What we found

We did not uphold the parts of Mrs B's complaint relating to the GP Surgery.

However, we found that there were clinical failings that affected Mr C's management and care in hospital. Although a specialised scan showed that Mr C had SBO, the clinician that treated him did not identify the condition. Mr C's condition deteriorated shortly after the scan and he suffered a cardiac arrest. He underwent 2 cycles of cardiopulmonary resuscitation ("CPR"). When the Health Board contacted Mrs B, she said that Mr C would not want to be resuscitated, but disputed saying that he "should be let go" (as noted in the clinical records). Clinical staff stopped CPR after 12 minutes and Mr C died.

We found clinical communication failings as well as failings in the DNACPR process. The Health Board should have asked Mr C about DNACPR procedure when he was admitted. Because it did not do so, it had to contact Mrs B as Mr C was undergoing CPR. We also found that CPR was not performed for the length of time specified in official guidance and that the decision to stop it was not informed by clinical considerations.

Overall, we decided that the clinical failings in Mr C's management and care amounted to an injustice to his family, who must live with the uncertainty that the outcome could have been different.

We also found that the way the Health Board handled Mrs B's complaint was not as effective or robust as it should have been. This meant that Mrs B and the family had to continue to relive the distressing events surrounding Mr C's death to obtain answers.

What our Investigation Officer said

Mr C had a right to give his views about whether CPR should be attempted. By failing to ask for his views when he could have expressed them, the Health Board placed an unfair burden on Mrs B.

This, and the manner of Mr C's death continues to haunt the family. The communication failings had also added to the ongoing and significant distress. For those reasons, we decided that the human rights of Mr C and the family (in particular, **Article 8**) had been engaged in this case.

What we recommended

In addition to an apology and financial redress to Mrs B for the complaint handling failings, we recommended that the Health Board engaged with Mrs B, on behalf of the family, to help them access financial compensation.

202101577

Cwm Taf Morgannwg University Health Board

Non-public interest report

Health

Mrs D complained about the care and treatment that her late husband (Mr D), received during his admission to hospital. Mrs D said that a DNACPR form was inappropriately placed on her husband's records against her wishes and without her permission.

She also complained that the decision to stop active treatment and move to end-of-life care after 3 days of admission was inappropriate and premature.

She said that Mr D was intentionally given morphine to overdose him and hasten his death. Mrs D also said that the Health Board did not sufficiently consider her views on these decisions.

Finally, Mrs D complained that Mr D was not discharged from hospital to allow him the opportunity to die peacefully in his care home. She said the Health Board's Bereavement Team did not contact her until several months after Mr D's death.

What we found

We found that the Health Board made the decision about DNACPR correctly. We also found that the decision to change to end-of-life care was reasonable, as Mr D's condition had deteriorated even though he had been receiving appropriate treatment.

The medications prescribed, including morphine, were appropriate and the Health Board communicated with Mrs D as it should have.

We also found that it would not have been possible for Mr D to have been discharged back to his care home because of how quickly he had deteriorated and the context of the COVID-19 pandemic. As a result, we did not uphold these complaints.

However, we upheld Mrs D's complaint relating to the Bereavement Team. The Health Board accepted that the bereavement support service set up during the pandemic should have contacted Mrs D far sooner.

What our Investigation Officer said

Mrs D said that the Health Board ignored Mr D's right to life (**Article 2)** because it decided to stop active treatment and, in her view, administered an intentional overdose of morphine. However, Article 2 places an obligation on the Health Board to provide life-saving treatment except in specific circumstances, such as where treatment is considered futile, or it is in the best interests of the patient not to provide it. The decision to stop active treatment was reasonable and we saw no evidence that morphine was prescribed to hasten Mr D's death.

What we recommended

The Health Board explained that the bereavement support service could not meet its usual timeframe of contacting family members because of staffing issues. It gave us information about the proportion of cases in which it was now meeting the relevant timescales. As the Health Board had already apologised to Mrs D and explained the reasons for the delay, we did not recommend further actions.

Other non-public interest reports

202003442

Cwm Taf Morgannwg University Health Board

Non-public interest report

Health

Mr A complained that the Health Board did not provide appropriate care and treatment to his late father, Mr B, after he suffered a stroke at home and was admitted to the Stroke Unit. Mr B had severe dementia and died in hospital several days after admission.

What we found

We found that, after admitting Mr B, the Health Board did not use the information from his family about his needs. It also did not complete robust tests to check his mental abilities. This would have helped the Health Board's staff to identify Mr B's needs relating to his dementia and make reasonable adjustments for him.

Mr B fell during his stay in hospital, and we found that the Health Board staff had not supervised him as they should have before he suffered that fall. We also found that the Health Board did not complete Mr B's observations as required on the day that he died.

We found that the Health Board's failings affected Mr B's dignity and safety. They also caused Mr A distress due to the uncertainty about whether Mr B's fall could have been avoided or his death prevented.

What our Investigation Officer said

We concluded that the Health Board had not paid due regard to the protection that Mr B, as a person living with dementia, was afforded by the **Equality Act 2010.** This was an injustice to him.

What we recommended

In addition to an apology and financial redress to Mr A for distress and uncertainty, we recommended that the Health Board should review and discuss Mr B's care with relevant clinical staff. We also recommended that it should provide equality related training for the care of patients with a cognitive impairment.

202000712

Cardiff and Vale University Health Board

Non-public interest report

Health

Mr D complained about the care and treatment that his late mother, Mrs C, received from the Health Board during 3 admissions to hospital over 3 months. Mr D said that during Mrs C's third admission the Health Board did not give her appropriate nursing care and did not promptly let her family know about her terminal cancer diagnosis.

What we found

We found that Mrs C's core nursing care plans were not adjusted to meet Mrs C's individual needs for personal hygiene, pressure relief and hydration. Because of that, the Health Board did not fully meet Mrs C's care needs and its nursing interventions were not always appropriate. We decided that this affected Mrs C's comfort and dignity.

We also found that the Health Board's medical staff were wrong to delay the planning of Mrs C's end-of-life care and to not tell her family about Mrs C's diagnosis, until she was in the last few days of her life. If that delay had not happened, it would have been possible for the Health Board to put in place the right support for Mrs C and her family when they needed it.

What our Investigation Officer said

Mr D told us that he felt "robbed" of the time that he would have shared with his mother had he understood her diagnosis and its implications sooner. Mrs C also became too unwell to express her wishes about where she would like to be cared for and to die. Mrs C and her family should have had the time to come to terms with her prognosis and to prepare for her death with end-of-life care support. We decided that this was a significant injustice to Mrs C and her grieving family and that it engaged Mrs C's **human rights** as an individual and her **family's rights** as part of wider family life.

What we recommended

In addition to an apology and financial redress to Mr D and his wider family for the distress it caused, we recommended that the Health Board shared the findings of our investigation with relevant staff for reflective learning.

201907544

Powys County Council

Non-public interest report

Social Services

Mr and Mrs A complained on behalf of their son, B, that the Council failed to safeguard and promote his welfare as a looked after child ("LAC"). They were also unhappy about how the Council handled their complaint.

A looked after child ("LAC") is a child who is in the care of their local authority.

What we found

We found that the Council did not follow the correct administrative process when it managed the funding of B's special educational provision.

We also found that the Council's decision to manage B under the statutory procedures for LAC was based on a wrong interpretation of the definition of "looked after".

The Council had also assumed that it had Mr and Mrs A's consent for B to be looked after without properly explaining their parental rights to them.

Finally, the Council's own investigation report noted how the Council failed to keep Mr and Mrs A informed of arrangements for B, including informing them as a priority when B had been admitted to hospital following a suicide attempt.

This lack of transparency and administrative failings caused an avoidable breakdown in the relationship between Mr and Mrs A and the Council. We also found numerous failings around how the Council handled Mr and Mrs A's complaint.

What our Investigation Officer said

The lack of transparency and administrative failings engaged Mr and Mrs A's human rights under **Article 6** and **Article 8**.

The Council had not assessed B's needs and so it could not show that it had regard to the human rights implications of the arrangements it made for him. Moreover, the Council did not recognise B's concerns when they were brought to its attention by B's parents. In this, it denied him any meaningful participation in the complaints process.

By failing to keep Mr and Mrs A appropriately informed of arrangements for B, the Council did not act fairly and in line with a human rights-based approach to the provision of children's social care.

What we recommended

We made several recommendations, including organisational learning, staff training and process reviews, in relation to record keeping, complaint handling and rights-based considerations in social work practice.

202005028 and 202104393

Betsi Cadwaladr University Health Board and Flintshire County Council

Non-public interest report

Health

Continuing Health Care (CHC) is a package of care for adults which is arranged and funded solely by the NHS. Who is eligible for this package is decided through assessment.

Mr C complained that the Health Board and the Council did not tell him in a timely manner about a dispute within the Health Board about Continuing Health Care (CHC) funding, which he expected to cover the cost of care home fees of his wife, Mrs C.

Mr C was also unhappy with the Council's role in his wife's discharge planning from hospital and the funding of her care at the care home.

Finally, Mr C was unhappy about how both bodies handled and responded to his complaint.

What we found

We upheld Mr C's complaints. We found that failings in the processes by the Health Board and the Council contributed to Mrs C having an outstanding social care debt of almost £20,000.

In terms of Mrs C's discharge planning and funding, the Council should have ensured that it informed Mr C of the financial implications of chargeable social care costs. It should also have discussed with Mr C, prior to Mrs C's discharge, the need to complete a financial assessment that would have helped him to reduce the cost.

What our Investigation Officer said

The ongoing stress impacted considerably on Mr C. The impact was exacerbated by uncertainty regarding Mrs C's living arrangements and past threats of eviction from her care home.

The quality of time that Mr C devoted towards caring for and supporting his wife had been compromised by dealing with the enormity of the accumulated debt.

As a result, we found that Mr and Mrs C's **Article 8** right to respect for private and family life, home and correspondence, had been engaged at a fundamental level.

What we recommended

In addition to an apology and a redress payment to Mr C in recognition of the distress and inconvenience caused to him, our recommendations also addressed the care home fees incurred by Mrs C, with the net effect of there being no outstanding fees for the relevant period.

202003764

Gwynedd Council

Non-public interest report

Housing

Ms A complained about how the Council manged her housing application and about its decision to offer her 2 properties which were unsuitable despite being aware of her partner's (Mr B's) ill health.

Ms A also complained that the Council's new Allocations Policy (a framework where people in most need of housing are prioritised) was discriminatory. That was because of one of the reasons why people could be prioritised - local connection - was based on a parent, sibling or child relationship and not other family unit types. Ms A said, that this meant that her needs were not prioritised as they should have been. Ms A also said that because of poor communication and other failings by the Council's Housing staff, she missed out on being shortlisted for properties.

What we found

We upheld many aspects of Ms A's complaints about the Council's administrative failings. We also found evidence that the communication by the Council was poor. However, we did not uphold Ms A's complaint that the Council's Allocations Policy was discriminatory.

What our Investigation Officer said

It was not unlawful for a council to set local connection as a reason to give priority to an applicant. 'Local connection' is not a protected characteristic under the **Equality Act 2010.**

Ms A and Mr B said that they were discriminated against because of Mr B's mental health and that there was a delay in them being allocated a property. However, we were satisfied from the evidence that Mr B's medical conditions were recognised and these were appropriately reflected in their housing application.

What we recommended

We made several recommendations to the Council about its administrative and communication processes.

202004278

Wales & West Housing Association

Non-public interest report

Housing

Mr Y complained that the Association did not appropriately investigate his complaints of Anti-Social Behaviour ("ASB") against his neighbour, another tenant of the Association.

Anti-Social Behaviour ("ASB") means acting in a way that causes or is likely to cause harassment, alarm or distress to one or more persons not of the same household as the perpetrator.

What we found

We found shortcomings in how the Association handled Mr Y's complaints about ASB. The Association communicated poorly and did not keep Mr Y informed about what actions it was taking in response to his complaints. These shortcoming were contrary to the requirements of its ASB Policy.

We also found that the Association had no ASB Procedure explaining how it would deal with occurrences of ASB. That was contrary to legislative requirements and caused an injustice to Mr Y as there was no ASB procedure for officers to follow in dealing with his complaint.

We also found, that although Mr Y informed the Association that he had some mental health issues, the Association did not update his records or ask him what his needs were, and whether he required reasonable adjustments. These shortcomings amounted to maladministration which caused Mr Y an injustice.

What our Investigation Officer said

Under the **Equality Act 2010**, public sector organisations are required to make reasonable adjustments for disabled people. This can mean changing policies and procedures or providing staff training to ensure that services work for those with protected characteristics.

These duties were relevant in this case because Mr Y informed the Association of his mental health issues and of the impact that the occurrences of ASB had on him.

What we recommended

In addition to an apology and some financial redress, the Association agreed to prepare and publish an ASB procedure. It also agreed that that procedure would include references to the Equality Act 2010 requirements and the duty to provide reasonable adjustments.

In addition, the Association agreed to review its ASB Policy to ensure that it complied with the requirements under the Equality Act 2010. It also agreed arrange training on those requirements and the ASB policy and procedure for its staff.

Public interest reports

202006310

Health

Cwm Taf Morgannwg University Health Board ("the First Health Board") and Swansea Bay University Health Board ("the Second Health Board")

Public interest report

Miss C complained about care and treatment provided to her cousin Ms F, by the First Health Board and the Second Health Board.

Miss C was concerned that the Health Boards missed opportunities to identify and treat the appendicitis that caused Ms F's ruptured appendix.

What we found

We did not uphold the complaint against the Second Health Board, because we decided that it was unlikely that Ms F had appendicitis during the time she was under its care.

However, we decided that the First Health Board failed to suspect appendicitis and admit Ms F to hospital on 2 occasions. It also failed to prescribe antibiotics and arrange appropriate and timely investigations.

After being examined for the first time, Ms F was sent home and told to return for a review and further investigations. When she returned to be examined again, a scan ruled out gallstones as a potential diagnosis. Nevertheless, Ms F was not admitted to hospital to be examined further.

Ms F did not return for further review and she died at home.

On the balance of probabilities, we decided that if the First Health Board had provided appropriate care, it would have identified and treated Ms F's appendicitis, and her death would have been avoided.

What our Investigation Officer said

We do not make the finding of avoidable death lightly. Moreover, it is likely that Ms F's final days at home would have been severely blighted by the pain and suffering caused by her undiagnosed appendicitis and infection. The discovery of her body within the family home must have been extremely traumatic for her family.

We decided that the circumstances of this complaint may have engaged the rights of Ms F and her family to respect for their private and family life under **Article 8.**

What we recommended

We recommended that the Health Board apologise fully to Ms F's family for its failings. We also recommended that it assisted the family in receiving financial compensation from the Health Board.

Finally, we recommended that our report was shared with relevant staff for wider learning and that the Health Board reviewed its practices and procedures in the Ambulatory Emergency Surgical Unit and ambulatory settings.

202000661 and 202001667

Betsi Cadwaladr University Health Board

and Denbighshire County Council

Public interest report

Health and Social Care

Mr D complained about his late mother's (Mrs M's) care at 2 hospitals.

Mrs M had bowel surgery (to initially deal with a cancer tumour). She then suffered with persistent nausea, abdominal pain, gastric issues, and consequent weight loss. Mr D said clinicians repeatedly talked about 'anorexia', making Mrs M feel it was her fault and that she needed to try to eat more and yet, when she did, she ended up in worse pain. By the time Mrs M's problems were correctly diagnosed, she was assessed as being too frail (in part from her extreme weight loss) to undergo surgery. Mrs M died the following day.

Mr D also complained that the Council did not offer Mrs M adequate home care support when she was first discharged, which he said impacted on her dignity. Mr D said that the Council assessed Mrs M as being able to climb the stairs to access the toilet – although she was unable to do so. As a result, Mrs M had to use a commode downstairs. Mr D said this caused Mrs M distress. He said the home care service had not been able to meet Mrs M's needs and there had been a 3-day gap in its provision. Due to a break down in this service, Mrs M was readmitted to hospital.

What we found

We found that clinicians did not notice that Mrs M had developed an ischemic bowel (a condition resulting from a reduced blood supply to the intestines). Neither did they identify other clinical signs for her nausea and extreme weight loss.

We could not be certain that Mrs M's death was preventable. However, we decided that because of the failures in Mrs M's care, the Health Board lost an opportunity to consider surgery before Mrs M became too clinically unwell to undergo it.

We also upheld Mr D's complaint about Mrs M's discharge and home care package, including about Mrs M's mobility assessment.

What our Investigation Officer said

Collectively (as well as individually), these failings impacted on Mrs M's **human rights in terms of dignity and quality of life**. There was also an impact on the wider **family's rights** in terms of their witnessing her debilitating decline.

We are always conscious that we cannot conclude that someone's human rights have been breached. However, the serious events here meant that we had to question whether proper regard was given to Mrs M's human rights in this case.

What we recommended

We made several recommendations. In addition to an apology and financial redress, we recommended that the relevant clinicians reflect on our report and undergo relevant training.

We also recommended that our report was shared with the Health Board and Council's Equalities Officers, to facilitate training to relevant staff involved in Mrs M's care on the principles of human rights in the delivery of care and services.

202005937

Cardiff Council

Public interest report

Waste Collection

Assisted Lift service helps residents who are unable to present waste for collection themselves due to disability, some medical conditions or pregnancy.

Equality Impact Assessment ("EIA") is a way of considering equality duties when planning and providing services.

The Council had committed to providing an Assisted Lift waste collection service to Mrs D, Mrs F and Miss P because these residents were disabled and could not present waste for collection themselves. However, they all complained that Cardiff Council's Assisted Lift Service had failed to meet their needs as vulnerable residents on a consistent basis. They also complained that the Council did not respond adequately to their reports and complaints about problems with the Assisted Lift Service.

What we found

We found that the Council did not provide a reliable Assisted Lift Service to the residents, with repeated missed waste collections over a long time. This amounted to serious service failures because some of the Council's most vulnerable residents were denied reliable access to an essential service that should be available to all. The residents, 2 of whom were in their 90s, should not have had to suffer such inconvenience for such a long time.

We also stated our view that, by providing the Assisted Lift service so inconsistently to its disabled residents, the Council's actions may have engaged the complainants' rights to reasonable adjustments under the Equality Act 2010.

In addition, we found that the Council's EIA did not adequately assess the impact of the Assisted Lift policy. That was because the assessment did not consider relevant operational evidence or engage with disabled or pregnant services users, or their advocates as required by specific equality duties in Wales.

We also upheld the complaints about the Council's complaint handling. Despite receiving repeated formal complaints and hundreds of calls from the complainants, the Council failed to properly acknowledge or act on their concerns and communicated with them poorly. We found that this caused the complainants avoidable distress over a long time, which amounted to a considerable injustice.

We found systemic problems with the Assisted Lift Service and were very concerned that the Council had not addressed those problems and that other vulnerable residents might also be affected.

What our Investigation Officer said

We found that this case may have engaged both human rights and equality duties. The way the Council provided the Assisted Lift Service (and failed to address the problems with it) meant that the residents had to endure accumulating waste, raising health and safety concerns and impacting their enjoyment of their homes. This may have engaged **Article 8**. It was likely that **Article 14** was also engaged, given the impact of the service failures on disabled residents.

Finally, in this case the duty to provide **reasonable adjustments** to disabled people was not enacted as it should have, and the impact on different equality groups among the residents was also not measured as it should have been.

What we recommended

We recommended that the Council should take several actions to put right the injustices experienced by the complainants, quickly improve the Assisted Lift Service for the benefit of all residents who used it, and show that it complied with its duties under the Equality Act.

The Council agreed to urgently update its EIA, to consider how it could minimise the need for complainants to report problems and make it easier for them to complain and speak to a supervisor promptly. It also agreed that the updated EIA should include plans for ongoing review of performance of the Assisted Lift Service, considering feedback from residents' reports and complaints.

Early Resolution

202201561

A GP practice

in the area of Cwm Taf Morgannwg University Health Board

Early Resolution

COVID-19

Mr A is autistic and complained that his GP Practice insisted he wear a face covering (mask) before he would be seen. That was despite Mr A saying that he was exempt from mask wearing because he was autistic. Mr A said that this had caused him anxiety and distress and meant that he did not receive his medication.

When Mr A complained to the GP Practice, it told him that mask exemptions did not apply to GP premises as they were a "high-risk healthcare setting". It said that it would make an allowance for those with "facial deformity unable to wear a mask" (this did not apply to Mr A).

What we found

Mr A's records confirmed that he had received his medication. However, we were concerned that the approach of the GP Practice did not comply with the regulations and guidance issued by the Welsh Government.

It was still mandatory in Wales to wear face coverings in health-care settings at the time of the events complaint about. However, guidance issued to GP practices indicated that mask exemptions could apply in health-care settings – whether for a mental or physical health reason.

What our Investigation Officer said

The GP Practice appeared to be acting contrary to Welsh Government guidance on mask exemptions. It seemed to take a restrictive approach without regard to either the guidance or the **Equality Act 2010.**

Autism is covered by that Act, and so Mr A had a reasonable excuse if he felt unable to wear a mask.

What we recommended

We resolved the case early, without the need for a formal investigation. The GP Practice agreed to apologise to Mr A for not acknowledging that he was exempt and for the distress this caused.

It also agreed to remind all its staff about the Welsh Government's guidance on exemptions - including that autistic people, and others whose conditions are not visible, may still be exempt.

202202881

Rhondda Cynon Taf County Borough Council

Early Resolution

Adult Social Care

Ms C complained that the Council refused to tell her about the health and whereabouts of her late partner, Mr D and did not inform her about his death until several months after he died. She also complained that the Council did not arrange for the administration of his estate, leaving her to attend to matters.

What we found

We found that it was not unreasonable in this case for the Council to withhold information about Mr D from Ms C in the weeks leading up to his death. However, after Mr D died, the Council showed a lack of urgency in establishing that information about his death could be passed to Ms C. This resulted in a 5 month delay in telling Ms C that Mr D had died, which was likely to have caused her avoidable additional distress.

We were also concerned that the Council should have provided appropriate advice and support to Ms C in relation to the settlement of Mr D's estate following his death, in as far as it affected her. Because it did not do that, Ms C was left to resolve matters on her own without support, which cost her avoidable time and trouble.

What our Investigation Officer said

Ms C's desire to receive information about her partner could have engaged her right to a private and family life under **Article 8**. We decided that in this case it was not unreasonable for the Council to withhold information prior to Mr D's death. However, the lack of urgency to find out if Ms C could be told about her partner's death could have engaged Article 8.

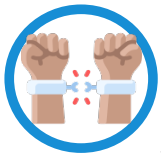
What we recommended

We resolved this complaint early, without resorting to a formal investigation. In addition to an apology and offering financial redress, the Council agreed to contact Ms C to offer her appropriate support and advice with any ongoing concerns relating to Mr D's estate.

Appendix: Some articles of the ECHR

Article 2 - The right to life - **an absolute right**

This includes the protection of life by public authorities. Article 2 can be relevant to consider where there is an allegation of avoidable death, provision of life saving treatment or delays in treatment. It places both positive (to do something) or negative (not to do something) obligations on public bodies.



Article 3 - The right to be free from torture or cruel, inhuman or degrading treatment or punishment - **an absolute right**

Torture has been defined as intentionally inflicting severe pain or suffering on someone. Inhuman treatment causes physical or mental suffering, so could be seen as cruel or barbaric but need not be intentional. Degrading treatment is extremely humiliating or undignified and, again, need not be intentional. To satisfy Article 3 the treatment would likely need to apply for hours at a stretch and can include neglect of duties, use of restraint, treatment against a person's wishes. Courts have set a high threshold for Article 3, but such considerations can often be viewed through Article 8 (right to respect for private and family life) as the impact on the individual is crucial.

Article 5 - The right to liberty and security - **a limited right**

This can apply when someone is detained in some way – i.e. re not free to leave. Consideration is given to the context and law – e.g. a person may lawfully be deprived of their liberty following a conviction and sentence by the courts. In mental health or care home settings we would consider the procedural safeguards put in place before any detention takes place – such as due process under the Deprivation of Liberty Safeguards.

Article 6 - The right to a fair hearing - **an absolute right**

The right to a fair trial relates to decisions about civil rights or in dealing with a criminal charge. Public bodies should meet this requirement too in their complaints handling processes in terms of procedural fairness. Has the public authority provided a reasoned decision, so someone knows the basis for it in order to decide whether to challenge it further (by any appeals process)? Does the composition of a decision body/panel ensure fairness and impartiality? A right to a public trial can be restricted if exclusion of the public is necessary to protect certain interests and/or if there is a right to progress to a court of tribunal that complies with that requirement.

Article 8 - The right to respect for private and family life, home and correspondence - **a qualified right**

This article is heavily linked to the FREDA principles of dignity, respect and autonomy. It can include sexual orientation/gender issues, the right to access information held about a person or the right to independent living and to make choices. There is a right to enjoy one's home without it being affected by noise or pollution and to enjoy living as a family, where possible. It can overlap considerably with the rights set out in Article 3 in matters of dignity.

Article 9 - The right to freedom of thought, conscience and religion - **an absolute (& limited) right**

While the right to hold a religious belief is absolute there are instances when the right to manifest it may be interfered with, so that aspect is a limited right – e.g. a pupil wishing to wear a traditional faith form of dress would be manifesting one's religion. However, if the school has a strict uniform code then it could insist that the pupil wear the uniform (thus interfering with the manifestation of their religion). They can still, nonetheless, hold their religious beliefs. There is a right to have children educated in accordance with religious beliefs albeit no duty on authorities to provide separate religious schools on demand. Healthcare bodies should protect an individual's right to manifest religious beliefs where it is practical to meet all the requirements.

Article 10 - The right to freedom of expression - **a qualified right**

Everyone has a right to hold opinions and express views even if sometimes they are unpopular. Interferences with them may be necessary in the interest of public safety, or to prevent the disclosure of information received in confidence

Article 14 - The prohibition of discrimination - **can only be used with other rights**

Heavily linked with the Equality Act, this right is not free standing and so can only be used if linked to one of the other human rights Articles.

Public Services Ombudsman for Wales

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	Population	Complaints Received	Complaints Received per 1000 residents (adjusted)	Complaints Closed	Within timescales %	20 days - 3 months %	3-6 months%	longer than 6 months%	Uphold %	Referred to Public Services Ombudsman for Wales	Referred %	PSOW Cases Closed	PSOW Intervened %	Early resolution %	PSOW Upheld%
Blaenau Gwent County Borough Council	69,609	61	1.75	60	48.33%	51.67%	0.00%	0.00%	56.67%	10	16.67%	10	0.00%	-	-
Bridgend County Borough Council	144,288	218	3.13	214	63.08%	35.51%	1.40%	0.00%	7.01%	29	13.55%	31	9.68%	100.00%	0.00%
Caerphilly County Borough Council	180,795	281	3.14	270	86.30%	13.33%	0.37%	0.00%	22.22%	26	9.63%	27	11.11%	100.00%	0.00%
Cardiff Council	362,756	1335	7.71	1405	57.08%	39.79%	2.78%	0.36%	52.46%	76	5.41%	80	15.00%	83.33%	16.67%
Carmarthenshire County Council	186,452	670	7.29	551	55.90%	43.92%	0.18%	0.00%	56.44%	33	5.99%	37	8.11%	66.67%	0.00%
Ceredigion County Council	73,076	63	1.66	49	55.10%	38.78%	6.12%	0.00%	51.02%	16	32.65%	22	40.91%	88.89%	0.00%
City of Swansea Council	245,480	998	8.35	803	86.67%	13.33%	0.00%	0.00%	33.87%	36	4.48%	38	7.89%	100.00%	0.00%
Conwy County Borough Council	116,863	189	3.28	188	86.17%	13.30%	0.53%	0.00%	30.32%	12	6.38%	16	12.50%	50.00%	50.00%
Denbighshire County Council	95,159	185	3.95	185	96.22%	3.78%	0.00%	0.00%	51.89%	16	8.65%	17	0.00%	-	-
Flintshire County Council	155,155	422	5.53	366	74.04%	25.96%	0.00%	0.00%	46.17%	35	9.56%	40	5.00%	50.00%	0.00%
Gwynedd Council	123,742	226	3.71	213	95.77%	4.23%	0.00%	0.00%	48.83%	18	8.45%	19	15.79%	100.00%	0.00%
Isle of Anglesey County Council	69,794	30	0.86	22	86.36%	13.64%	0.00%	0.00%	13.64%	18	81.82%	19	21.05%	75.00%	0.00%
Merthyr Tydfil County Borough Council	59,953	336	11.43	289	100.00%	0.00%	0.00%	0.00%	31.49%	9	3.11%	10	10.00%	100.00%	0.00%
Monmouthshire County Council	93,590	97	2.12	92	60.87%	38.04%	1.09%	0.00%	58.70%	9	9.78%	9	0.00%	-	-
Neath Port Talbot County Borough Council	142,090	97	1.39	93	80.65%	19.35%	0.00%	0.00%	10.75%	19	20.43%	18	5.56%	100.00%	0.00%
Newport City Council	151,485	613	8.41	606	78.71%	21.29%	0.00%	0.00%	2.48%	18	2.97%	21	19.05%	100.00%	0.00%
Pembrokeshire County Council	124,711	391	6.39	287	89.20%	10.80%	0.00%	0.00%	38.33%	19	6.62%	19	10.53%	100.00%	0.00%
Powys County Council	132,515	321	4.83	285	85.26%	13.68%	1.05%	0.00%	73.68%	21	7.37%	27	14.81%	100.00%	0.00%
Rhondda Cynon Taf County Borough Council	239,127	410	3.50	346	77.46%	21.97%	0.58%	0.00%	40.17%	29	8.38%	30	3.33%	100.00%	0.00%
Torfaen County Borough Council	92,264	56	1.23	57	94.74%	5.26%	0.00%	0.00%	68.42%	6	10.53%	7	14.29%	100.00%	0.00%
Vale of Glamorgan Council	130,690	311	4.92	198	78.79%	21.21%	0.00%	0.00%	39.39%	28	14.14%	23	26.09%	100.00%	0.00%
Wrexham County Borough Council	135,571	408	6.05	419	97.61%	2.39%	0.00%	0.00%	46.54%	25	5.97%	28	7.14%	50.00%	50.00%

Wales	3,125,165	7,718	4.92	6,998	76.41%	22.75%	0.77%	0.07%	40.35%	508	7.26%	548	12.04%	87.88%	6.06%