Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

The Annual Report 2005/06

of

The Commissioner for Local Administration in Wales
The Welsh Administration Ombudsman
The Health Service Commissioner for Wales
The Social Housing Ombudsman for Wales





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Contents

1 Introduction

The Public Services Ombudsman (Wales) Act 2005 received Royal Assent in April 2005. In October 2005, the National Assembly for Wales passed the necessary Order to bring the Act into force with effect from 1 April 2006.

Accordingly, this is the last time that I will report on my four previously separate jurisdictions as the Commissioner for Local Administration in Wales; the Welsh Administration Ombudsman; the Health Service Commissioner for Wales and the Social Housing Ombudsman for Wales (the latter being a short lived office since it only came into being in July 2005).

Not surprisingly, the main focus of activity in my office during 2005/06 was on preparing for the introduction of the Public Services Ombudsman (Wales) Act while continuing to deal with the caseload of enquiries and complaints already on hand. This placed great demands on my staff and I wish to record here my sincere thanks to each and every one of them for their support, hard work and achievements over the past year.

Adam Peat

Adam Peat
Ombudsman

2 Transition and continuity: my role as Ombudsman in 2005-06

During the year under review I was necessarily operating to the legislation applicable to the then existing four Ombudsmen schemes, and continued to employ two nominally separate groups of staff. However so far as practicable my office operated in practice as a single entity, with harmonized procedures, so that there has been a period of shadow running as Public Services Ombudsman for Wales.

The essence of my role across the various jurisdictions was to investigate impartially complaints made by members of the public that they had been treated unfairly by a public body, or had received a bad service through some fault on the part of the body providing it.

The legislation in each case required that (unless I saw good reason to make an exception) I should not investigate a complaint unless the complainant had first raised the matter directly with the body concerned and given it a reasonable opportunity to investigate and respond. (In the case of NHS complaints, the complainant had normally to have first exhausted the NHS complaints procedure).

My investigations were undertaken in private. Where I published a report it was anonymised to protect, so far as possible without compromising the effectiveness of the report, the identity not only of the complainant but also of other individuals involved.

However, only a minority of my investigations were pursued to the issue of a formal report. In some cases where I judged that the complaint should not be upheld, the existing statutory procedures for the issue of a report would have been unduly cumbersome and expensive (a local authority was obliged to pay for publicity for any report which I issued concerning it, regardless of whether or not the complaint was upheld). In other cases my intervention led the authority concerned to make a satisfactory offer of redress, and where no issue of wider public interest arose, I was happy to discontinue my investigation on that basis.

Where I did decide to issue a report, the legislation required that a report relating to a local authority should be made public; other reports were not published but I was under a duty to send to the First Minister of the National Assembly a copy of all reports I made as Health Service Commissioner and as Welsh Administration Ombudsman. In all those cases where I found that a member of the public had suffered an injustice, I made recommendations to the public body concerned about what it should do to make amends to the complainant. Where I found that the injustice had arisen from some systemic failing, I also made recommendations aimed at reducing the risk that similar problems would recur in the future. My recommendations were without exception accepted by the bodies concerned (although in one case I had to make a further report to a local authority to achieve this outcome).

Another aspect of my role as Local Government Ombudsman was to investigate (under the provisions of the Local Government Act 2000) complaints that members of local government bodies had broken their authority's code of conduct. Where I find evidence that a member has significantly breached the code, I am required to submit a report setting out the evidence either to the authority's standards committee, or (generally in more serious cases) to the President of the Adjudication Panel for Wales. It is for the standards committee or a tribunal to consider the evidence I have found together with any defence put forward by the member concerned, and determine whether a breach has occurred and, if so, what penalty if any should be imposed.

3 Workload across all four jurisdictions

3.1 Complaints Caseload – Comparison 2005/06 against 2004/05

2005/06 saw a marked increase in the number of new complaints received – as the following table shows, the number of new cases increased overall by 386, making the total well over a third higher than in the previous year.

	Local Government		Health	Welsh Administration	Social Housing	Total
	Complaints	Allegations				
Cases carried over from 2003/04						308
New cases 2004/05	676	175	159	42	-	1,052
Total casework 2004/05						1,360
Cases carried over from 2004/05						477
New cases 2005/06	904	281	180	45	28	1,438
Total casework 2005/06						1,915
Cases to be carried forward to 2006/07						410

* Social Housing was a new responsibility from 15 July 2005.

The overall casework, which included cases carried over from the previous year, saw an increase of 555 cases during 2005/06 compared to 2004/05. It is pleasing to see that despite the marked increase in caseload received during 2005/06, the number of cases being carried forward to 2006/07 is brought down to 410 from the 477 carried over from 2004/05 to 2005/06; that is a reduction of 67 cases being carried forward. I am confident that this improvement in performance in closing cases has been achieved whilst maintaining a rigorous examination and investigation of cases.

3.2 Decision Times

The following table shows the time taken to close cases from the time that we have received a complaint form or letter.

Whilst I am pleased that over 70% of the complaints received by my office were dealt with within six months, too many cases have taken over 12 months to complete and I have set challenging targets for 2006/07 to improve on the overall current performance.

Time taken	%
within 3 months	51
3 - 6 months	20
6 - 9 months	12
9 - 12 months	7
12 - 18 months	7
18 - 24 months	3
	100

3.3 Summary of outcomes

Set out below is a summary of the outcomes of the cases closed during the past year:

Complaints		No. of complaints
Out of jurisdiction		287
Premature		213
Insufficiently serious		41
Discontinued:		
No evidence of hardship or injustice	80	
No evidence of maladministration or service failure	327	
Complainant failed to provide requested information	62	
Complainant withdrew complaint (no local settlement)	24	
Other reasons	1	494
'Quick Fix' (i.e. early settlement at Ombudsman's suggestion without full investigation)		36
Voluntary Settlement (following Ombudsman's investigation)		110
Report issued: complaint not upheld		18
Report issued - complaint upheld:		
Redress – apology	7	
Redress – change in listed authority procedures	15	
Redress – other action by listed authority (excluding financial redress)	9	
Redress – change in listed authority procedures plus other action by listed authority (excluding financial redress)	5	
Redress with financial redress alone or financial redress plus apology	4	
Financial redress plus change in listed authority procedure	14	
Other Redress	1	55
Total Outcomes - Complaints		**1,254**

Allegations	
Decision not to investigate allegation	154
Allegation investigation discontinued:	
Discontinued	8
Discontinued, referred to Monitoring Officer	11
Allegation Outcome (brief report):	
No evidence of breach	45
No action necessary	22
Allegation Outcome (full report):	
Refer to Standards Committee	11
Refer to Adjudication Panel	8
Total Outcomes - Allegations	**259**
Total Outcomes	**1,513**

4 Report of the Commissioner for Local Administration in Wales

4.1 Complaints: overview and statistics

County/County Borough Councils

Complaints about local government in 2005-6 were up by a third on the previous year – 904 compared with 676. However I have seen nothing to suggest that this marked upturn is due to a deterioration in councils' performance. It seems much more probable that the enhanced profile of the Ombudsman's office and the new publicity leaflets sent out at the beginning of the year led to a greater awareness amongst members of the public and advice agencies such as Citizens' Advice Bureaux and Shelter Cymru that redress for serious complaints could be sought via the Ombudsman. That has to be a good thing.

Of more concern was the increase in the number of formal public reports upholding a complaint - 15 - which I issued during the year. That compared with a particularly low figure of only 4 such reports in the previous year. However this is still a very small proportion of the total complaints which I considered, and reflected in part the emergence during the year of what proved to be a widespread problem in councils' housing service – a failure to come fully to grips with the implications of the Homelessness Act 2002. In a number of cases which I reported on, this led to applicants for housing or for homelessness assistance not being given the help or the degree of priority which they should have received. This led me to make the first Special Report - guidance addressed to all 22 county councils - ever issued by the Local Government Ombudsman for Wales.

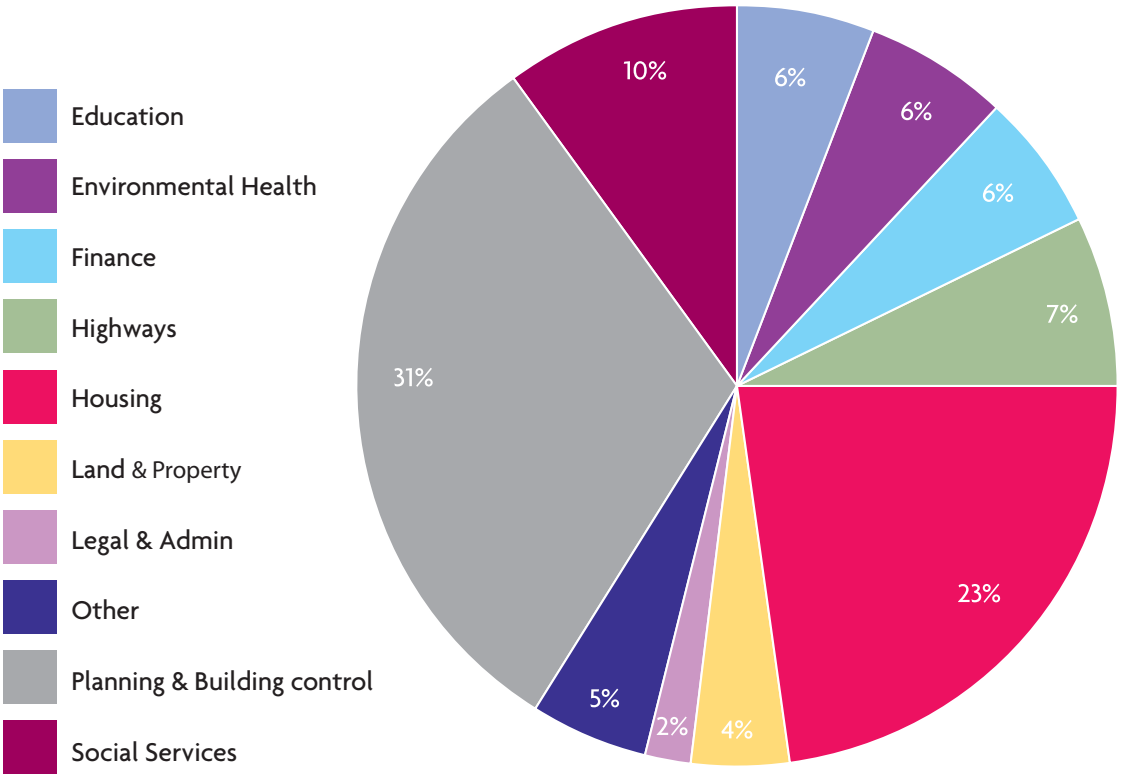
Such Special Reports have been issued comparatively frequently in recent years by the Local Government Ombudsmen for England. I was pleased therefore to have the opportunity of collaborating with them, also for the first time, in producing a joint Special Report addressed to all Councils in England and Wales on the subject of memorial safety in local authority cemeteries. I intend to look out for future opportunities to share relevant learning from Ombudsman investigations in this way. I deal in more detail with these two Special Reports at page 17.

The following table gives details in respect of the complaints received against each of the 22 county and county borough Councils in Wales.

Authority	Total Complaints (b/fwd and new in year)	Out of jurisdiction	Premature	Discontinued	Settlement (quick fix)	Voluntary settlement following investigation	Report issued (not public) – upheld investigation	Public report issued: complaint upheld	Remaining open as at 31/3/06
Blaenau Gwent	25	5	2	10		1		1	6
Bridgend	31	6	3	13	1	2		1	5
Caerphilly	78	10	5	37	5	6		1	14
Cardiff	100	19	9	37	2	6		2	25
Carmarthenshire	96	9	11	38	4	6			28
Conwy	52	13	6	16	2			1	14
Ceredigion	42	9	3	14	1	1		1	13
Denbighshire	39	8	8	13	1	2			7
Flintshire	47	8	3	22		4		1	9
Gwynedd	63	6	10	32		2	1	2	10
Isle of Anglesey	48	12	2	25		2			7
Merthyr Tydfil	50	11	8	10	2	5		1	13
Monmouthshire	29	5	2	12				1	9
Neath Port Talbot	54	10	10	23		1			10
Newport	47	9	4	15	3	3			13
Pembrokeshire	61	12	7	21	1	7		1	12
Powys	61	20	6	17	1	3			14
Rhondda Cynon Taff	56	6	7	22		5		1	15
Swansea	85	16	17	27	3	6		1	15
Vale of Glamorgan	52	10	8	19	3	3			9
Torfaen	41	11	3	14	2	6			5
Wrexham	60	23	3	19	3	2			10
TOTAL	1,217	238	137	456	34	73	1	15	263

Complaints received by service area in 2005/06

The chart below breaks down by service area the complaints received against county councils. Planning (particularly development control) and housing continue to be the service areas most frequently complained of.



Other Bodies in jurisdiction

There are a number of other bodies that fall under my jurisdiction as Commissioner for Local Administration for Wales and details of complaints received in respect of these are set out below:

Authority	Total Complaints (b/fwd and new in year)	Out of jurisdiction	Premature	Discontinued	Settlement (quick fix)	Voluntary settlement	Public report issued - upheld	Still open as at 31/3/06
Environment Agency	**5**	**1**	**1**	**2**				**1**
Educational Bodies								
Appeals Panel - Caerleon Comprehensive School	1						1	
Appeals Panel - Lakeside Primary School	1			1				
Appeals Panel - Penglais School	1					1		
Appeals Panel - Whitchurch High School	1						1	
Appeals Panel - Cardiff High School	1	1						
Corpus Christi Governing Body	1	1						
TOTAL	**6**	**2**		**1**		**1**	**2**	
National Park Authorities								
Brecon Beacons National Park Authority	14	2	2	8		1		1
Pembrokeshire Coast National Park Authority	5	2		4				
Snowdonia National Park	4	1		2		1		
TOTAL	**23**	**5**	**2**	**14**		**2**		**1**
Police Authorities								
North Wales Police Authority	2				1			1
South Wales Police Authority	3	2				1		
TOTAL	**5**	**2**			**1**	**1**		**1**

4.2 Complaints: Issues of Special Interest

Special Report: Housing Allocations and Homelessness

A number of complaints received by my office concerning housing allocations and homelessness issues revealed a widespread problem with how such applications were dealt with. A significant number of the 22 Welsh local authorities had failed to introduce housing allocation and homelessness policies and procedures that implemented in practice the relevant legislative requirements, in particular those introduced by the Homelessness Act 2002. This Act took effect on 27 January 2003 and it was very disappointing to find that three years on from that date some councils had yet to adopt and implement appropriate policies. As a direct result of these shortcomings in policies and procedures, I found in a number of investigations across different authorities that individuals who had applied for social housing or for homelessness assistance had not received the assistance or the degree of priority to which they should have been entitled.

I decided to issue, in February 2006, the first ever special report issued by an Ombudsman in Wales, bringing together the lessons learnt from these investigations of individual complaints. I recommended that all Welsh county and county borough councils should review as a matter of urgency the lawfulness of their policies and procedures in the light of the guidance and recommendations contained in my special report. This special report is available on my website or from my office in hard copy.

Joint Special Report with the Commission for Local Administration in England: Memorial safety in local authority cemeteries

In recent years, a number of local communities both in England and in Wales have been shocked and aggrieved by the actions of councils laying flat hundreds of grave memorials as a result of health and safety inspections. To people visiting after the event it looked as though vandalism on a large scale had desecrated their cemeteries. My colleague Ombudsmen in England and I found councils at fault because of: failure to ensure adequate publicity/notification before carrying out stability testing or laying down individual monuments which failed the test; not having proper systems in place for risk assessment and subsequent prioritisation of work; lack of proper training for those carrying out testing; and failure to take account of ways in which memorials can

be made safe without laying down. In our view, with proper planning, staff training and awareness of the alternatives, it should not be necessary to lay down grave memorials on any large scale.

I believe that if councils in Wales take note and learn from the good practice set out in this Special Report, they should be able to ensure public safety whilst avoiding the degree of upset and distress to members of the public that has sometimes been caused in the past. This special report is available on my website or from my office.

Further Report: Conwy County Borough Council

In September 2005, I reported to Conwy County Borough Council on my investigation of a complaint about the Council's treatment of a homeless family, referred to as Mr and Mrs White. I found that there had been maladministration by the Council, and in particular, that aspects of the Council's housing allocations policy were unlawful. This had caused injustice to Mr and Mrs White. I recommended that the Council should make suitable redress to Mr and Mrs White, and I further recommended that the Council should revise its housing allocations policy to comply with the requirements of the law and take account of the relevant statutory guidance.

The Council considered my report at its meeting on 15 December 2005. The minute of the meeting recorded that the Council resolved in part –

"... That the Council does not accept the recommendations within the Ombudsman's report because the Council does not agree with the legislation as it has a detrimental affect on local people."

Notwithstanding the resolution referred to above, the Council's Cabinet at its meeting on 20 December 2005 considered the Council's housing allocation policy and approved the amendment recommended to make the policy comply with the law. However, that left unremedied the personal injustice to Mr and Mrs White caused by the Council's maladministration.

Under the provisions of the Local Government Act 1974, if I am not satisfied with the action which a local authority has taken or proposes to take in response to my report of an investigation into a complaint, I am under a duty to issue a further report.

In February 2006, therefore, I issued a special report, which recommended that the Council should give further consideration to my original recommendations in respect of making amends to Mr and Mrs White for the injustice they had suffered from the Council's maladministration. Those recommendations were that the Council should pay Mr and Mrs White the sum of £1500 in recognition of the additional expense the White family necessarily incurred and the distress and inconvenience suffered by the family; and that the Council should now place Mr and Mrs White on the Council's waiting list, backdating their date of joining to 8 December 2004.

I called on members of the Council to keep the requirements of the law and of the code of conduct for members clearly in mind when giving further consideration to my report and recommendations for redress to Mr and Mrs White. I urged them to reflect that it would be unfair and wrong to vent their frustration with the law on homelessness on one particular family who were in unfortunate circumstances not of their making. I am pleased to report that at a meeting on 2 March the Council accepted my recommendations in full and that the family concerned have now received fair redress.

This was the first time since local government reorganisation in 1996 that it had been necessary for the Local Government Ombudsman for Wales to issue a further report.

4.3 Complaints: sample case summaries

Cardiff County Council: Council Tax Benefit

Mr Thomas had applied for Council Tax Benefit (CTB) and submitted full evidence of income with the application. One item, a share certificate, was returned to him immediately as he was told "its value could not be assessed". There was a delay in assessing his application beyond that allowed for in the CTB Regulations and when he received his determination letter denying him benefit because his income was too high, he saw that it was incorrectly assessed. The amount entered on the system was too high as the period default setting on the Council's software had not been overridden by the assessor.

Mr Thomas was asked for evidence of his shareholdings and queries were raised as to his bank details. Mr Thomas took exception to these enquiries, particularly as he had submitted his share certificate with his application and felt his integrity was being questioned in relation to his bank account. He started to complain through formal channels and then encountered numerous communication difficulties, including failure to return his telephone messages. An award of CTB was made and then he received a further letter telling him his entitlement had increased further. This turned out to be due to a software error affecting claims from pensioners which took four months to resolve.

Notification letters sent out by the authority were of poor standard and frequently incorrect. Communication difficulties continued and Mr Thomas sought to escalate his complaint but stopped when matters appeared to be resolved. Later he wrote to advise of some changes in his income and enclosed supporting evidence. From this the Council established that one of his benefit payments had increased early in his claim and he had not notified them of this.

Some 19 weeks later this resulted in his CTB being withdrawn from the start of his entitlement resulting in an excess CTB of £355. He was sent three letters on the same date each covering a different time period and giving computerised calculations. The letters did not give clear or adequate reasons for the change, the calculations nor the proposed recovery action and Mr Thomas did not understand what was happening. At this point he complained to me.

When later advised of the reasons, Mr Thomas, a first time claimant, said he thought the Council would be notified direct of changes to state benefit payments. He had otherwise been diligent in providing information to the Council.

The CTB regulations require that a local authority process new applications within 14 days or as soon as practicable thereafter, similarly changes in circumstance should be dealt with in a timely manner normally before the Monday following notification of a change where a reduction in benefit was taking place. It is the responsibility of the claimant to notify of changes which may affect entitlement, failure to do so means that any resulting overpayment is recoverable. However the authority is obliged to consider whether or not it is appropriate to recover given the circumstances of the particular case.

Determination letters should give explanation of the reasons for any change to entitlement, explanation of how calculations have been arrived at and reasons for any proposed action.

I concluded that the authority had failed to comply with the regulations in respect of processing times and had made a number of errors in calculations, one of which had been repeated a second time. I found that there was insufficient evidence that the Council had properly considered whether or not to recover the excess CTB and in view of the poor service Mr Thomas had received over an eighteen month period he felt that more sympathetic consideration was warranted. The authority only reviewed the case at a late stage in the investigation and then waived the over-payment.

Although the authority had a performance management system in place, it had failed Mr Thomas on numerous occasions and I recommended a review of its effectiveness. I also recommended re-training of staff on steps to be taken in making decisions on overpayment recovery and that the Council should review its IT contract provisions and standard letters to ensure an improved service to customers. I recommended an apology and a payment of £250 in recognition of Mr Thomas's time and trouble in pursuing these matters.

Blaenau Gwent Council: Social Housing

Mrs Jones complained about the Council's handling of her application for social housing. She had been waiting for over two years to be housed. She lived in a one-roomed caravan with four young children, the children were in poor health as the caravan was damp, overcrowded and there were few amenities on the site. She said she had been repeatedly 'fobbed' off by the Council and that other families she knew appeared to be housed ahead of her. She had approached her Councillor, MP, Shelter Cymru and various health professionals, who had all made written representations on her behalf. She had asked to be nominated to a housing association.

A joint complaint was made to me by Mrs Jones and by Shelter Cymru, when the latter had received no replies to four letters enquiring about Mrs. Jones's housing position and prospects.

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Social housing in the area was provided by the County Borough Council which ran a housing register and had only "ad hoc" arrangements with one of the local housing associations whereby they would advise the Council if they had a property to offer to one of their applicants. There were no formal nomination arrangements in place.

The Homelessness Act 2002 requires authorities to implement a system for allocating properties which provides reasonable preference to five defined categories, for example homelessness applicants or people who occupy insanitary or overcrowded housing. It placed a responsibility on local authorities to pro-actively assess an applicant's circumstances in order to establish whether they were homeless, an applicant should not need to approach the authority in a particular way or apply to be as treated as homeless in order to trigger the authority's responsibilities.

I found that the allocation policy which the Council had in effect at the time of the complaint was drafted under the Housing Act 1996 and completely failed to reflect the requirements of the Homelessness Act 2002 and the Code of Guidance issued by the National Assembly in 2003.

I looked into the pointing of Mrs Jones' application and the area choices the Council had registered her for and found that both had been incorrect throughout the period of her application. Had Mrs Jones' case been correctly administered, it was probable that she would have been housed within months of her application. It was established that many other applicants with fewer points had been housed ahead of her.

I found weaknesses in the authority's handling of correspondence and that they never made pro-active assessments of applicants for possible homelessness status. They did not have satisfactory arrangements in place for dealing with the assessment of medical aspects of applications resulting in no medical points being awarded to Mrs Jones, despite the ill-health of her children and supporting letters from health professionals.

I described the administrative arrangements within the authority's housing department as lamentable and concluded that had her application been handled correctly Mrs Jones would have been housed within months rather than years of her application.

In view of the seriously inadequate housing conditions experienced by the family for over two years, I recommended that the Council should make a payment to the family in the sum of £5,000 and issue an apology. They had, by the time of the report, been housed.

I further recommended that the Council introduce an allocation scheme in line with legal requirements and that they review all current housing applications to ensure they were correctly assessed. The authority was also recommended to institute improved procedures for assessing medical priority and for the handling of correspondence with the housing department.

Gwynedd Council: Leisure

Mr & Mrs White complained through their Assembly Member that the Council had failed to respond adequately following their son David's accident at a swimming pool managed by the Council; and that the Council had failed to undertake a proper investigation into the formal complaint submitted by Mr & Mrs White.

David, who was 10 years old at the time, had been swimming with friends at the Council's pool when he sustained an injury to his arm on metalwork segregating the pool area. He went to the showers whilst help was sought from the pool duty officer employed by the Council. Despite the wound bleeding profusely, it was claimed that the officer had sworn at David and not administered first aid. Later that evening Mr & Mrs White took David to the local hospital casualty department where he had 5 stitches administered to close the wound.

Mr & Mrs White visited the pool the following morning to meet with the pool manager then on duty. It became apparent that the accident was not recorded in the accident book in accordance with the Council's own published practice. They complained to the Council but only received a response some months later following a reminder issued by solicitors Mr & Mrs White had engaged. The Council said it was undertaking a full investigation into the complaint. No further response was received until a further request was made by Mr & Mrs White's Assembly Member. It was by then a year since David's accident occurred. The Council's response confirmed that the file had originally been misfiled resulting in delay. The full investigation and disciplinary hearing of the duty officer had however been concluded some 4 months earlier.

The Council acknowledged that the process of investigation took longer than it should. It accepted that it had failed to communicate the outcome to Mr & Mrs White when it should have.

A council has a common law duty of care to users of its leisure facilities and also a statutory obligation to comply with the provisions of The Health and Safety (First Aid) Regulations 1981. These include provision of adequate and relevant equipment and facilities to administer first aid where an injury has occurred. Operational procedures should also be in place for the safety of users of leisure facilities including arrangements for the recording of accidents.

I found that the Council had failed to respond properly to and deal with the accident suffered by David. Whilst there was no evidence to suggest the Council was responsible for the accident occurring, it had failed to follow its own procedures in that the accident had not been recorded in the Accident Book at the pool and first aid had not been administered to David's bleeding wound as required. Neither had the accident been subsequently recorded when Mr & Mrs White visited the following day.

The Council had further failed to respond in a timely way to Mr & Mrs White's formal complaint. It had failed to follow the timescale laid down in its own complaints procedure, failed to promptly instigate a full investigation and failed to inform Mr & Mrs White of the outcome of the final disciplinary and complaints hearing.

I was satisfied that the Council had failed to properly carry out a full investigation and that David had not been dealt with as he should have following his accident. This had resulted in David and his parents suffering distress in the period immediately following the accident and subsequent frustration at the delay in dealing with their legitimate complaint. Mr & Mrs White had also suffered the inconvenience of having to engage the services of a solicitor and enlist the help of their Assembly Member to get the Council to take notice of their complaint.

The Council confirmed that as a result of the investigation it had undertaken a review of its health and safety and disciplinary procedures to avoid the reoccurrence of the delay. A complaint tracking system was also being developed for the Council's Monitoring Officer as an additional safeguard.

The Council also agreed to my recommendation that it should immediately apologise to both David and Mr & Mrs White for the shortcomings identified. It also agreed to the recommendation to offer David the sum of £100 as compensation for the distress suffered as a result of his treatment after the injury and to offer Mr & Mrs White the sum of £250 for their inconvenience and trouble in pursuing the complaint.

Monmouthshire County Council: Planning

Mrs Perkins complained that the Council failed to notify her of a planning application by her neighbour for permission to extend his two bedroom bungalow to create a four bedroom, two storey house, and she was thereby denied the opportunity to object. I found that the Council wrote to notify Mrs Perkins and the occupiers of other neighbouring properties of the application. However, the Council accepted that its letter to Mrs Perkins was incorrectly addressed and that she did not receive it. The Council did not erect a public notice near the application site.

No objections to the application were submitted to the Council. The Council's Head of Development Control subsequently approved the application.

Seven months later, a further application was submitted to the Council by Mrs Perkins' neighbour, which concerned increasing the size of a bedroom window which overlooked Mrs Perkins' property. No neighbours were notified of the proposed amendment, which was approved by officers as a "minor amendment".

A year later, Mrs Perkins noticed the extent of the building work being undertaken by her neighbour. She contacted the Council and was told about the planning consent that had been granted for the extension. Mrs Perkins complained that she had not been consulted about the development and that it was intrusive to the amenity of her property.

As a result of the subsequent investigation of her complaint, the Council accepted that Mrs Perkins had not been consulted on her neighbour's application, which was in contravention of legislative requirements and its own development control procedures. An order was served on Mrs Perkins' neighbour, which imposed a condition that he install obscure glazing in the bedroom window that overlooked Mrs Perkins' property.

I considered the Council's failure to consult Mrs Perkins on the application and its amendment to be maladministration which had caused injustice to Mrs Perkins, as she had lost two opportunities to object to the development. There was no evidence to suggest that any objections by Mrs Perkins would have prevented the development, but a condition to install obscure glazing in the overlooking bedroom window may have been attached to the planning consent from the outset.

I recommended the Council reviewed its development control procedures, apologised to Mrs Perkins, compensated her for the costs of planting to help screen her property from the neighbouring development and compensated her for her time and trouble in pursuing the complaint.

The Council accepted my recommendations. It reconfigured its development control function and introduced a new IT system to attempt to prevent similar errors. It apologized to Mrs Perkins and paid her £800 in compensation.

City and County of Swansea: Social Services

The complainant has a young son who is severely disabled and unable to walk upstairs. Adaptations to the family's home to provide a downstairs bedroom and bathroom facilities were recommended by the Council's occupational therapist, but as a result of a test of his resources, the complainant was not eligible for a mandatory disabled facilities grant under the housing legislation.

The complainant then applied to the Council for assistance under Section 2 of the Chronically Sick and Disabled Persons' Act 1970. Despite its duties under the Children Act 1989 (regarding children in need) and under the 1970 Act, and despite guidance issued by the Welsh Office (Circular 59/96) the Council did not have a policy for dealing with such requests. It delayed in dealing with the complainant's request, and failed to give proper consideration to the report submitted by the occupational therapist which recommended that the Council's Social Services provide financial assistance for the necessary adaptations. The Council eventually informed the complainant that it had decided not to provide financial assistance and advised him to apply for a disabled facilities grant even though he had already explored that route with the Council and established that on the basis of their income, he would not be eligible for grant assistance.

The complainant pursued the matter further by means of a complaint to their Assembly Member, but there were further delays by the Council in responding to the Assembly Member. The Council's response to the Assembly Member (which reaffirmed its decision not to provide financial assistance) contained erroneous information regarding the complainant's resources, namely that he was supporting his other children in private education.

I concluded that the absence of a proper policy to deal with requests for assistance under the 1970 Act and the Council's delays amounted to maladministration. He concluded that in consequence, the complainant and his son had suffered an injustice in that they were deprived of the opportunity of having their request for financial assistance considered in a fair and proper manner and in accordance with the law. However, I found no maladministration by the Council in the way in which it reconsidered the complainant's application for a disabled facilities grant under its new housing grants policy. That led to the potential availability of a grant towards the cost of the adaptations which the complainant declined.

The Council subsequently adopted a social services policy for dealing with requests for assistance under the 1970 Act. It agreed to my recommendation that it reconsider the complainant's request for financial assistance in accordance with the new policy. It has also agreed to review any other cases where it may have a duty to provide assistance under the 1970 Act, and to review its complaints procedures.

Finally, the Council agreed to make a compensatory payment to the complainant of £2000 in recognition of the impact of its failures on the family and their son and in recognition of their time and trouble in pursuing their complainant with me.

Gwynedd County Council: Social Services

A mother complained of the way in which Social Services dealt with her concerns, which she brought repeatedly to their attention over a considerable period, that one of her children was abusing others in the family. She considered that the Council failed to assess the risk presented by that child. She also highlighted administrative shortcomings in the Child Protection Conference procedures and claimed that the Council had not provided the necessary respite. Overall she said that the Council's failings had caused the break-up of the family.

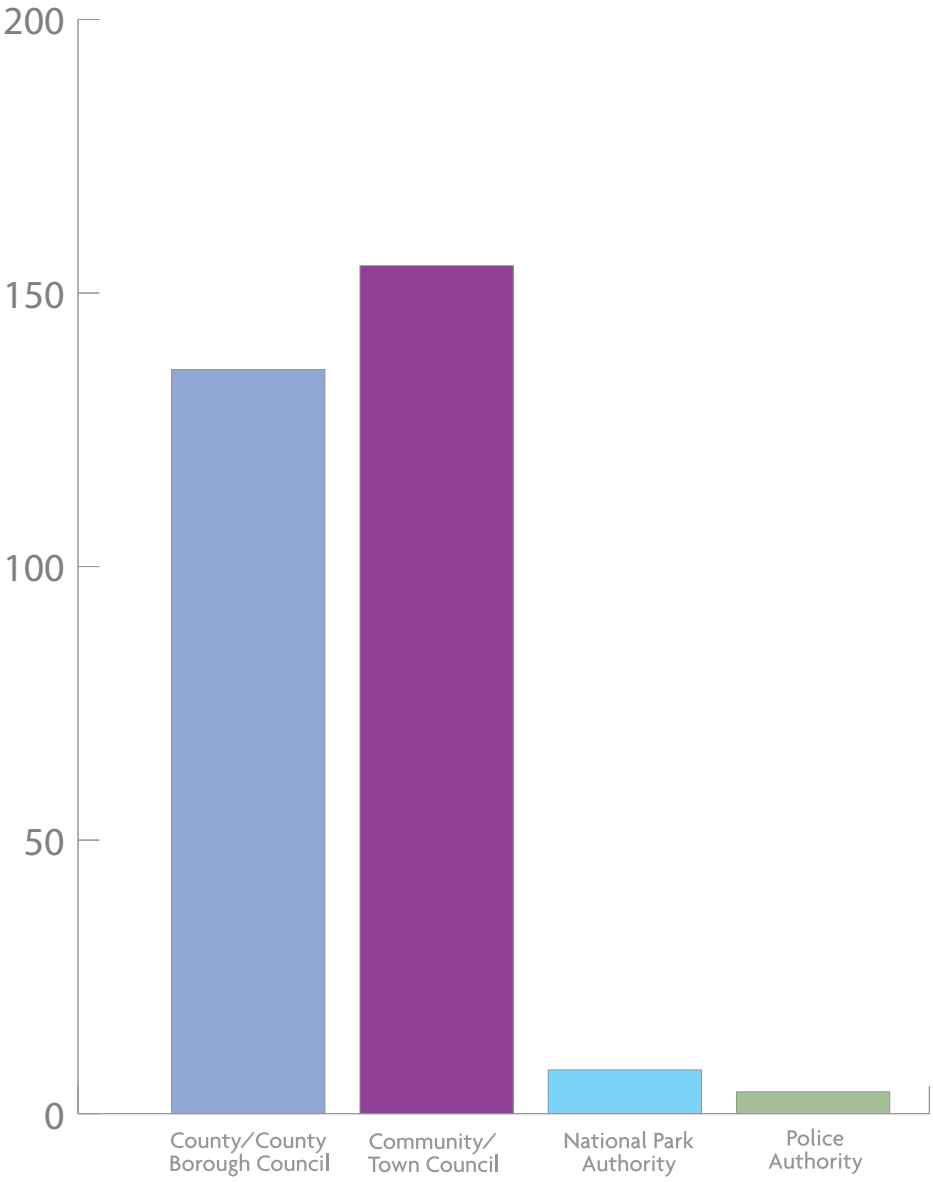
I found that the Council had failed to take the mother's complaints seriously and to carry out the necessary investigation. Most significantly it also failed to address the risk presented by the one child. This failure caused distress and inconvenience to the family. I found that the Council failed to meet the child's respite needs as identified in her care plan. I also upheld the mother's complaint about administrative shortcomings in relation to Child Protection Conferences. I expressed concern that the Council had not dealt with her complaints under its internal complaints procedure within the required timescales. I recommended that the Council should pay the mother £750 and that payments of £1,500 each should be put in trust for three of her children. I also recommended that changes should be made to ensure that the administrative shortcomings identified in relation to Child Protection Conferences do not recur and in particular that their recommendations are monitored at a senior level to ensure that they are effectively implemented.

I directed that my report should not be published in this case because of the sensitivity of the information relating to the children in the family.

Further summaries (plus full investigation reports) are available on my website: www.ombudsman.wales.org.uk

4.4 Allegations of misconduct: overview and statistics

The graph below shows that allegations against community/town councillors are the largest group of allegations received. This is a continuation of the trend of previous years. Of course, it does have to be borne in mind that there are 736 community councils in Wales and a correspondingly large number of community councillors.



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I stated in my report last year that many of the allegations I received were trivial in nature, and this has continued to be the case during 2005/06. I would reiterate here my concern that a handful of community councils give rise to a disproportionate number of such allegations. Often these are by members of the council against another member of that council apparently on a 'tit-for-tat' basis. In a few cases it appears to me that personal animosities may be adversely affecting the ability of the council to serve the community effectively. I have warned all members of two community councils against making vexatious allegations, which is itself a breach of the code of conduct.

At the other end of the spectrum, there have been a small number of cases where I have found evidence of misconduct which warranted reference to the Adjudication Panel for Wales. Whilst there were no such referrals during 2004/05, I found cause to refer 8 such cases during 2005/06 (7 of these were in respect of county council members and 1 in respect of a community council member). Further details in respect of my investigations are set out in the tables that follow.

County/County Borough Council	Total Allegations	Decision not to investigate	Discontinued	Discontinued: Referred to Monitoring Officer for further investigation	No Evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Remaining Open as at 31/3/06
Blaenau Gwent	5	2					1	1	1
Bridgend	4	1	1		1				1
Caerphilly	8	2			3			1	2
Cardiff	5	2			2			1	
Carmarthenshire	2	1			1				
Conwy	1				1				
Ceredigion	3	2			1				
Denbighshire	1								1
Flintshire	2		1						1
Gwynedd	3	1					2		
Isle of Anglesey	17	7		1	2	1	1		5
Merthyr Tydfil	6	3	1		1	1			
Monmouthshire	5	3			1				1
Neath Port Talbot	2	2							
Newport	3	1				1		1	
Pembrokeshire	10	4	1	1	2		1	1	
Powys	2				1				1
Rhondda Cynon Taff	6	1			1	1	1	2	
Swansea	37	28			4	2			3
Vale of Glamorgan	4	1		2	1				
Torfaen	3	2			1				
Wrexham	7	3			2		2		
TOTAL	**136**	**66**	**4**	**4**	**25**	**6**	**8**	**7**	**16**

Community/Town Council	Total Allegations	Decision not to investigate	Discontinued	Discontinued: Referred to Monitoring Officer for further investigation	No Evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Remaining Open as at 31/3/06
Abertillery & Llanhilleth	1					1			
Aberystwyth	1	1							
Bettws	1	1							
Bryngwran	1	1							
Caernarfon	4	4							
Caldicot	10	10							
Clydach	1							1	
Coedffranc	1						1		
Crickhowell	2	2							
Llanfaelog	1						1		
Dunvant	16	5			4				7
Graig	1								1
Grovesend	6					6			
Halkyn	9	9							
Hay	1	1							
Henllan Fallteg	1						1		
Holyhead	1	1							
Killay	2			1					1
Llanaelhaearn	3				3				
Llandudno	1	1							
Llaneilan	2								2
Llanelli	2	2							

Community/Town Council	Total Allegations	Decision not to investigate	Discontinued	Discontinued: Referred to Monitoring Officer for further investigation	No Evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Remaining Open as at 31/3/06
Llanfair Mathafarn Eithaf	4	2				1			1
Llanidloes	1								1
Llantilio Crossenny	1	1							
Maesteg	1	1							
Manorbier	9	2	2		4	1			
Marloes & St Brides	6				6				
Monmouth	10	8	1		1				
Mostyn	2		1						1
Neath	1	1							
Penllergaer	1			1					
Pontypool	1	1							
Pontypridd	1								1
Porthcawl	2	1			1				
Rhyl	1					1			
Rhymney	2	2							
Shotton	2	2							
St Brides Major	28	16		5	1	1			5
St Brides Minor	1					1			
St Florence	1	1							
Sully	9	6							3
Talybont-on-Usk	3	2							1
TOTAL	**155**	**84**	4	**7**	**20**	**12**	**3**	**1**	**24**

Authority	Total Allegations	Decision not to investigate	Discontinued	Discontinued: Referred to Monitoring Officer for further investigation	No Evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Remaining Open as at 31/3/06
Brecon Beacons National Park Authority	3					3			
Pembrokeshire Coast National Park Authority	1					1			
Snowdonia National Park	1	1							
North Wales Police Authority	3	3							
TOTAL	8	4				4			

4.5 Allegations of misconduct: sample case summaries

A member of Blaenau Gwent County Borough Council

I received an allegation by Councillor X that Councillor Y (who was the Leader of the Council) had failed to comply with the Council's code of conduct for members. He alleged that in 2002 Councillor Y promised to provide office facilities for Councillor X's group of members if he (Councillor X) and his group of members supported Councillor Y's preferred candidate for the post of chief executive. Councillor X said that he agreed to Councillor Y's proposition and alleged further that in June 2004 after the office facilities had been provided that Councillor Y then withdrew them contrary to the promise he had made.

It appeared evident that Councillor X himself must necessarily have committed a breach of the code if the matters alleged by him were substantially found to be true. Conversely, if the matters alleged were not substantiated, then it appeared that he may have breached the code by making a malicious allegation against Councillor Y, and in publicising his allegation, behaved in a manner which could be reasonably regarded as bringing the office of member or the authority into disrepute.

I concluded on completion of the investigation that there was no evidence of a breach of the code of conduct by Councillor Y. Councillor X had failed to produce convincing evidence and neither of the witnesses he named were able to corroborate his claims. What evidence there was supported Councillor Y's version of events, namely that his agreement to provide office facilities for Councillor X's' group of members was unrelated to the appointment of the chief executive. The evidence indicated that he had given consideration to the provision of office space for Councillor X's group of members some months before the arrangements were made for the shortlisting and interviewing of candidates for the post of chief executive.

In concluding that the allegation made by Councillor X against Councillor Y was wholly without foundation, I concluded also that the nature of the allegation was such that there was no possibility of it having been made in honest error. I concluded that Councillor X's action in making the allegation against Councillor without some evidence in support of his claims constituted a malicious complaint.

Although Councillor X denied sending details of his allegation to the press and although the investigation failed to establish how details of the correspondence appeared in the local press, the evidence indicated an intention by Councillor X that the matter be made public. I concluded that Councillor X's conduct had brought both the office of councillor and his authority into disrepute.

My finding was that the matters regarding Councillor X which were the subject of the investigation should be referred to the President of the Adjudication Panel for Wales by adjudication by a tribunal.

Two members of Wrexham County Borough Council

I received an allegation from a councillor against another member of Wrexham County Borough Council. The basis of the allegation was that the Councillor concerned, who was the Leader of the Council and a member of the Executive Board, failed properly to declare an interest in a matter which came to the Board for a decision and failed to withdraw from consideration of the matter.

On the basis of the information before me I concluded that the Councillor concerned had breached the Council's code of conduct, by failing to declare a personal interest under paragraph 11 of the code and to withdraw from the Executive Board meeting when a proposal to reorganise schools in the Rhos area of Wrexham was discussed. I appreciate that the Councillor concerned had received advice from the Monitoring Officer to the effect that having declared an interest in the matter he could remain in the meeting, speak but not vote. However this advice was given on the basis of his interest as a governor of schools likely to be affected by the proposals, an interest falling within paragraph 12 of the code. The Monitoring Officer said that at the time he gave the advice he was unaware that the Councillor's sons attended one of the schools which would be affected by the proposals. A Monitoring Officer can only advise a member accurately if that member acquaints him with all the material facts. I concluded that it should reasonably have occurred to the councillor to consider that he had a further interest which he needed to declare as the father of children attending a school which would be affected by the proposals.

My finding under section 69 of the Local Government Act 2000 was that my report on this investigation should be referred to the Monitoring Officer of the Council, for consideration by the Council's Standards Committee.

I also received an allegation that another Councillor who was member of the Executive Board of Wrexham County Borough Council had breached the code of conduct in relation to a proposal to reorganise schools in the Rhos area. That Councillor received advice from the monitoring officer via the Leader to the effect that having declared an interest in the matter he could stay in the meeting, speak but not vote. However, this advice was given on the basis that his interest was as a governor of schools likely to be affected by the proposals, an interest falling within paragraph 12 of the code. The Councillor concerned did not tell the Monitoring Officer that he had grandchildren at one of the schools. It should reasonably have occurred to the Councillor to consider that he had a further interest which he needed to declare, as the grandfather of children attending one of the schools which would be affected by the proposals.

My finding under section 69 of the Local Government Act 2000 was that my report on this investigation should be referred to the Monitoring Officer of the Council, for consideration by the Council's Standards Committee.

A member of Clydach Community Council

I received an allegation from a shop proprietor against a member of Clydach Community Council. The proprietor alleged that the councillor had breached the provisions of the Council's Code of conduct in that his behaviour in her shop on two separate dates were such as to bring the office of councillor into disrepute by virtue of his abusive attitude towards herself and two members of her staff. Moreover, he had improperly attempted to obtain a discount on a private purchase by misrepresenting it as a purchase on behalf of the Community Council; and had made threats against her business when this was refused.

There was a clear conflict of evidence between the statements made by the proprietor and her staff on the one hand, and by the councillor on the other as to what took place during the councillor's visits to the shop. The councillor was accompanied by members of his family during those visits, but was reluctant to involve them as witnesses for personal family reasons. I therefore had to consider the councillor's unsupported word against clear and consistent accounts from the shop proprietor and the three members of her staff who were involved at one time or another.

The proprietor and her staff all confirmed that the purchase was represented as being made on behalf of the Community Council and that all subsequent discussions about a discount hinged on this point. They all also said, as people accustomed to dealing with members of the public, that the Councillor's behaviour was unacceptable on both visits. I saw no reason to believe that the proprietor or her staff would have fabricated their story, and I had no hesitation in preferring their evidence to that of the councillor concerned. The documentary evidence also pointed to the purchase having been misrepresented by the councillor.

My finding under section 69 of the Local Government Act 2000 was that my report should be referred to the President of the Adjudication Panel for Wales for adjudication by a tribunal.

A member of Pembrokeshire Coast National Park Authority

My predecessor received an allegation that a councillor had breached the Authority's Code of Conduct. It was alleged that in February 2002 he failed to declare an interest as a director of a development company in proposals contained in the joint unitary development plan for Pembrokeshire relating to the allocation of land for housing development but nevertheless participated in discussions, and voted, on the issue. As the matter was being investigated by the police the Ombudsman's investigation was discontinued. After the police ended their enquiries, the complainant provided new evidence and the investigation was reopened.

The councillor owned a very substantial area of land within the National Park, and also a company with "development" in its title and as its principal registered business activity. I was not persuaded by his claim not to have had any development in mind as at February 2002, when I found there was evidence that he did in June 2001 and in July 2004 on the same site.

Whatever the councillor's stated reasons for opposing the proposed policy, the decision was on a policy which could affect the value of his land holding. The proposed policy could reasonably be regarded as likely to disadvantage him. He failed to declare an interest and spoke and voted on the policy in breach of the code. My finding under section 69 of the Local Government Act 2000 was that my report should be referred to the President of the Adjudication Panel for Wales for adjudication by a tribunal.

A member of Rhondda Cynon Taff County Borough Council

I received an allegation from Mrs Y that a councillor had breached Rhondda Cynon Taff County Borough Council's Code of Conduct for Members, when he wrote a letter to the court. The letter was read out during family court proceedings relating to access arrangements for the complainant's grandchildren. The letter stated that the councillor was the brother of Mr X, who was involved in the proceedings. The councillor stated in the letter that he was a County Borough Councillor and Community Councillor and signed the letter as such.

Mrs Y alleged that the councillor had breached the Code of Conduct, in that he had used his position improperly to secure an advantage for a member of his family.

This allegation from Mrs Y came on top of a separate, and in my view more serious, allegation against the councillor concerned, which I had received from one of his constituents, Mrs Z. Mrs Z alleged that the councillor had breached the Council's Code of Conduct when he sent her a series of electronic mail messages (e-mails)in response to a complaint she had made to him. Mrs Y alleged that the tone and content of the e-mails were in breach of paragraph 4(a) of the Code of Conduct, which required members to show respect and consideration for others. She also alleged the councillor breached paragraph 6.1(b), as his behaviour could be reasonably regarded as bringing the office of Member or the Authority into disrepute.

I decided to investigate both allegations simultaneously, and both were covered in a single interview with the councillor. During the course of the investigations into the allegations by Mrs Y and Mrs Z, my investigator was informed that the councillor had been convicted of a criminal offence in August 2004. Enquiries were made with South Wales Police, who confirmed that the councillor was convicted of driving with excess alcohol in 2004. The commission of a criminal offence by a member breaches the Code of Conduct.

In relation to Mrs Y's allegation, I concluded that the councillor had breached the Code of Conduct as alleged.

I considered the first two e-mails sent from the councillor to Mrs Z to be acceptable. However, the councillor's tone changed dramatically in his third e-mail, which was sent late at night. The councillor said that he received intervening e-mails before he sent his third e-mail, which led him to respond in that way. However, the councillor had not produced any evidence of such further e-mails. Mrs Z said she did not respond to his e-mails at all. I preferred the evidence of Mrs Z to that of the Councillor on this point. The councillor accepted that his third e-mail was aggressive and offensive to Mrs Z.

I then addressed the matter of the councillor's repeat conviction in 2004 for drink-driving. The councillor had sought to advance the view that this conviction was a traffic violation and not a criminal matter. He was misguided. A conviction by the magistrates' court for driving with excess alcohol is indeed a criminal offence and the sentence imposed reflected the seriousness with which the court regarded the matter.

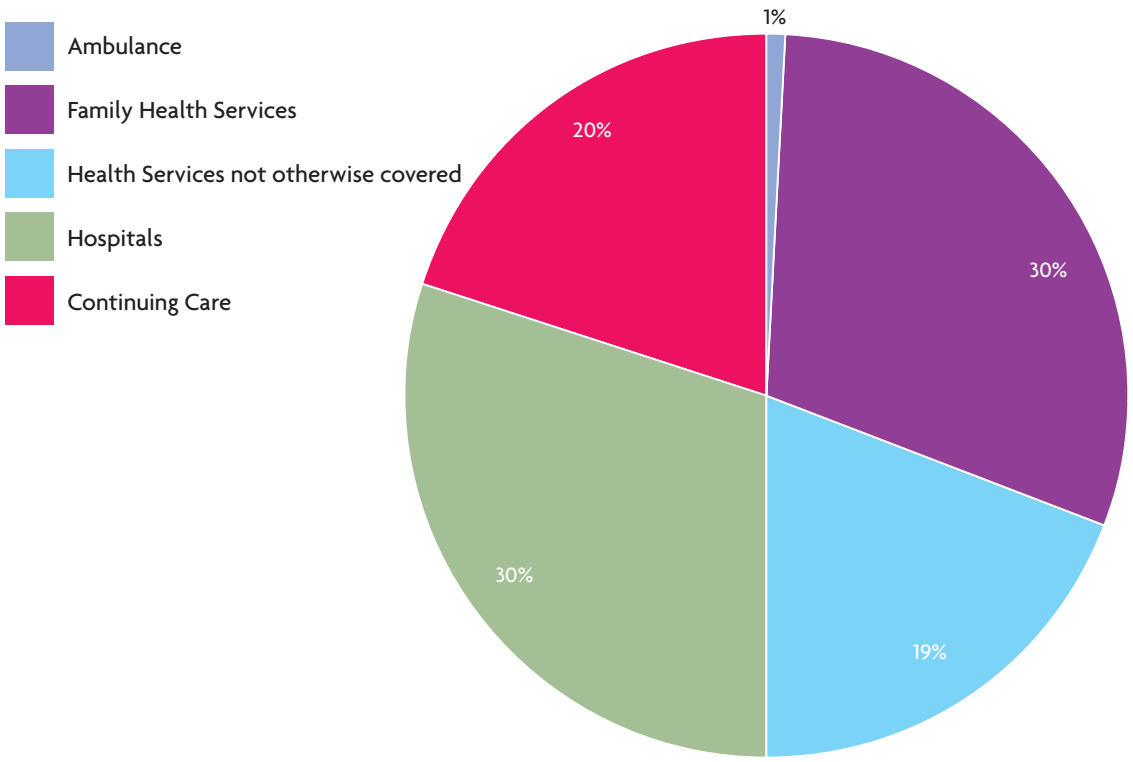
My finding under section 69 of the Local Government Act 2000 was that these matters should be referred to the President of the Adjudication Panel for Wales, for adjudication by a tribunal.

5 Report of the Health Service Commissioner for Wales

As Health Service Commissioner for Wales, I investigate complaints made by members of the public who feel they have suffered because of unsatisfactory treatment or service provided by, or on behalf of, the National Health Service in Wales, including family doctors (GPs), dentists, pharmacists or opticians. I can also consider complaints of failure and criticize the actions and decisions of clinical staff, where appropriate, without having to consider whether they amount to maladministration. I will normally draw on the assistance of appropriate professional advisers in considering complaints that have a clinical element (which is the great majority of cases). A panel of advisers is maintained on an England and Wales basis, with costs appropriately shared via a service level agreement with the Health Service Commissioner for England.

5.1 Overview and Statistics

As the chart below demonstrates, the largest areas of complaint received were in respect of family health services and hospitals. However, it is notable that continuing care cases in themselves accounted for 20% of the health caseload and I give particular attention to this matter later in this report.



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The pages that follow give further details on the complaints received in respect of the individual Local Health Boards, NHS Trusts in Wales, together with information on complaints against GPs, dentists, etc. As can be seen, I issued 27 reports which upheld the complaint made to me and 13 where the complaint was not upheld. Under the legislation in existence in 2004/05, I am not able to make these reports public.

Local Health Board	Total Complaints (b/fwd and new in year)	Out of jurisdiction	Premature	Discontinued	Settlement (quick fix)	Settlement	Report Issued (not public) – upheld	Report Issued (not public) not upheld	Remaining Open as at 31/3/06
Anglesey	1	1							
Blaenau	3		2				1		
Bridgend	1						1		
Caerphilly	1			1					
Cardiff	4			1	1	1	1		
Carmarthen	2			1					
Carmarthenshire	1					1		1	
Ceredigion	1			1					
Conwy	5		1	1			1		
Denbighshire	1							2	1
Flintshire	3		1						1
Gwynedd	1							1	1
Monmouthshire	3		2			1			
Neath Port Talbot	2		1						1
Newport	6			1					3
Pembrokeshire	2		1				2		1
Powys*	38	1	1	7		8			11
Rhondda Cynon Taff	5					3	4	6	1
Swansea	1		1				1		
Torfaen	1								1
Vale of Glamorgan	4			1		2			1
Wrexham	2			1					1
TOTAL	**88**	**2**	**10**	**15**	**1**	**16**	**11**	**10**	**23**

*Powys Local Health Board is also responsible for All Wales Continuing Care Panel (see page 46 for further information)

NHS Trust	Total Complaints (b/fwd and new in year)	Out of jurisdiction	Premature	Discontinued	Settlement (quick fix)	Settlement	Report Issued (not public) – upheld	Report Issued (not public) not upheld	Remaining Open as at 31/3/06
Bro Morgannwg	8		3	2			1		2
Cardiff & Vale	27	1	10	4		3	4		5
Carmarthenshire	6		1		1				4
Ceredigion & Mid Wales	2								2
Conwy & Denbighshire	13	1	4	1		1	2		4
Gwent Healthcare	20	1	3	4		1	4	1	6
North East Wales	12	1	1	1		1	1	1	6
North Glamorgan	7		2	2		1	1		1
North West Wales	9		2	1					6
Pembrokeshire & Derwen	11	2	1	6					2
Pontypridd & Rhondda	3		1	1					1
Swansea	18	1	8	1			3		5
Velindre	1	1							
Welsh Ambulance Services	2					1		1	
TOTAL	**139**	**8**	**36**	**23**	**1**	**8**	**16**	**3**	**44**

Authority	Total Complaints (b/fwd and new in year)	Out of jurisdiction	Premature	Discontinued	Settlement	Report Issued (not public) – upheld	Report Issued (not public) not upheld	Remaining Open as at 31/3/06
GP/GP Practice	33	2	9	7	1	5		9
Dentist	1							1
Out of hours service - Gwent Healthcare NHS Trust	1		1					
Out of hours service - Primecare	1							1
Panteg Health Centre	1							1
St Dunstons Nursing Home	1	1						

5.2 Issues of Special Interest: Long Term Care

Last year's annual report referred to my concern about the number of complaints I had received in relation to long term care. I reported on the work that my office had undertaken in relation to this matter. I noted that in early 2004, an all-Wales continuing care review panel was set up by Powys LHB (which had inherited the liabilities of the old health authorities under the NHS reorganisation) to hear claims for reimbursement for cases prior to 1 April 2003.

I also reported last year that I had begun to receive complaints from some complainants expressing concern about the way that the Special Review process itself was being conducted and that I would thus be following this matter up during 2005/06. This I have done and a number of common issues of concern came to the fore about the operation of the all-Wales continuing care review panel. Briefly, these involved a lack of explanation for the panel's decision; unavailability to the applicants of records being made available for consideration by the panel; and about the eligibility criteria used by the panel.

I met with the Chief Executive of Powys LHB in October 2005 and we agreed the following improvements to procedures:

- The letter sent to claimants by the chairs of the all-Wales panels notifying them of the panel's decision would in future give specific reasons why the particular decision has been reached in each case.
- Whilst not all applicants will wish to see the records considered by the panel, Powys LHB agreed that applicants would be advised a reasonable period before the panel hearing that they may request a copy of the records should they so wish, and this would be provided to them if they did so.
- Powys LHB would send out key documents to panel members beforehand. The sections of evidence considered by the panel, and their reasons for doing so, would be clearly documented.

- Powys LHB would put into writing additional explicit guidance for panel members regarding the need to take note of and apply the lessons of the 1999 Court of Appeal judgement - known as the Coughlan judgement - in all of the cases presented to them. This was in order to prevent the possibility that the eligibility criteria may be being applied too restrictively if the amendments made to the former Health Authorities' criteria following the Coughlan Judgement were not made clear to the person implementing them. This guidance should ensure a common frame of reference across Wales. Powys LHB undertook to share a copy of the draft of this guidance with my office for comment prior to issuing it.

I am pleased to say that all of these steps have subsequently been implemented.

5.3 Sample case summaries

Powys Local Health Board & Newport Local Health Board: Continuing Care

Mr D complained to me about the decisions taken with respect to his late mother's entitlement for continuing care. Mr D's late mother, Mrs D, was diagnosed with Alzheimer's disease in February 2000, and entered hospital in May 2001. During the admission, the clinicians involved concluded that due to her dementia, it would not be safe for her to return home, and Mrs D was discharged to an EMI (elderly mentally infirm) residential home in June 2001. She remained there until admitted to a second hospital in October 2003, where she stayed until her death in January 2004.

Following a special report published in February 2003 by the Health Service Ombudsman for England about NHS funding for long term care (commonly known as "continuing care funding"), Mr D became concerned that his mother had not been deemed eligible for NHS continuing care funding and made a complaint to the former Gwent Health Authority in March 2003. He argued that as his mother suffered from Alzheimer's disease she had a "health need" and was therefore entitled to have all her care paid for by the NHS. He also argued that the Health Authority's criteria for assessing whether individuals were eligible for NHS funding were unlawful. Mr D was dissatisfied with the Health Authority's response and requested an independent review of his complaint. Following advice from the Welsh Assembly Government , the independent review process was suspended in October 2003 and the complaint referred back to Newport LHB (as successor body to the Health Authority).

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In early 2004, an all-Wales continuing care review panel (the all-Wales panel) was set up by Powys LHB (which had inherited the liabilities of the old health authorities under the NHS reorganisation) to hear claims for reimbursement for cases prior to 1 April 2003.

The all-Wales panel heard Mr D's claim in February 2005. The panel overturned a recommendation made by Newport LHB that Mrs D had not been eligible at all for NHS funding, and awarded a reimbursement for the period March-October 2003 (up to the time when Mrs D entered hospital). Mr D was unhappy that the panel decided his mother was only entitled for funding for part of the period claimed. He believed that the investigation of the case by Newport LHB was inadequate, which caused their recommendation to the panel to be flawed. Mr D complained, too, that the input of Mrs D's family was not sought by Newport LHB during the investigation of his claim for reimbursement. He also complained that the consideration of his case by the panel was inadequate; in particular that not all relevant information was considered, and that the panel did not provide an adequate explanation of why Mrs D was not eligible for NHS funding for the period before March 2003.

I found that Newport LHB had not directly elicited Mr D's views during the investigation of his claim; however, he had made his views clear on a number of occasions in correspondence to them. He also submitted a detailed representation to the panel setting out his claim. I found that despite having had nearly two years in which to do so, Newport LHB had not obtained, or seen, copies of the residential home records until the day before the panel hearing. As a consequence, the LHB's recommendation to the panel did not refer to these. Only copies of the home's records for the period from October 2002 until Mrs D's final admission to hospital were obtained by Newport LHB for consideration by the panel.

I found that in overturning Newport LHB's recommendation, the panel relied substantially on the information contained in the residential home records. I was concerned, therefore, that the panel did not have sight of, and had not requested to see, the full record before reaching its decision. I was concerned, too, that the explanation given to Mr D was inadequate, which meant that he needed to seek clarification from the panel secretariat.

In common with other complaints made to him about the operation of the all-Wales panel, I was also concerned that Mr D was not given an opportunity to be provided with a copy of the records obtained for the consideration of the panel in advance of the hearing, nor were all the records provided to the panel members in advance. I also had concerns that the eligibility criteria used by the panel to assess whether Mrs D qualified for continuing care funding were potentially open to interpretation in an overly restrictive way.

I found that the actions of Newport LHB had amounted to maladministration in that they had not obtained all the necessary records to enable them to make a robust recommendation to the panel. I did not feel that the actions of the LHB were unreasonable in relation to requesting information from Mr D, as Mr D had an opportunity to present his case to the panel. However, I did feel that the LHB may wish to review its practice to identify how the views of claimants and/or their representatives might be better reflected in their reports to the panel.

I found, too, that Powys LHB had acted maladministratively in that the panel had not required to see the remainder of the care home records before reaching its decision. I felt that it would have been difficult for the panel to have been able to say for certain whether or not Mrs D was eligible for the earlier period claimed by Mr D without seeing all the records. I also criticised the standard of the initial explanation given to Mr D for the panel's decision which he did not feel was sufficiently detailed to enable Mr D to understand why the panel had reached the conclusions it had.

At my recommendation, Powys LHB agreed to hold a fresh panel to re-hear Mrs D's case. They agreed to ensure that all relevant records were made available for the panel's consideration, and to provide a full explanation of the panel's decision to Mr D.

I also recommended that Newport LHB should ensure in future that all relevant records are obtained when investigating claims for continuing care funding.

Rhondda Cynon Taff Local Health Board: Continuing Care

Mr A's father, Mr B, was admitted to a care home in 2001 following a stay in hospital. He was suffering from Alzheimer's disease. He was funding his own care. In 2003 Mr A became aware of the Health Service Ombudsman's special report on continuing care. He felt that his father should be entitled to funding due to his health needs and duly made a complaint to the Rhondda Cynon Taff Local Health Board in April 2003. A full continuing care assessment was not completed until the following year and Mr B was deemed to be ineligible for funding. The view was endorsed by the by the All Wales Special review Panel in November 2004. Mr A remained dissatisfied and complained to me about the excessive delay and the fact that he felt that the eligibility criteria had been applied too restrictively in his father's case. He also complained about some of the processes of the panel hearing, particularly that there was no scope for legal representation at the hearing, there was insufficient time allowed and that there would have been insufficient time for the panel to consider nearly 4 years of Mr B's medical history.

I found that it was impossible to say whether the eligibility criteria had been applied over-restrictively as the assessment did not detail Mr B's needs against the criteria and no rationale had been presented as to how the ineligible decision had been made. The decision letter was inadequate as it did not provide any reasons as to how the decision had been reached.

In respect of the process, I found that not all the papers had been presented to the panel, nor had they been provided to the claimant beforehand. I was satisfied that the panel system had been set up on a non-adversarial basis so that claimants did not need legal representation. Allowing legal representation would not be of any benefit to claimants. In respect of the time allowed for the hearing, as the start and finish times of hearings are not recorded, it was impossible to reach a conclusion on this matter. I recommended procedural changes to the panel process though in making this recommendation I recognised that many of these had already been addressed by Powys Local Health Board following my meeting with the Chief Executive. I recommended that a fresh panel with all the relevant documents should be held to consider Mr B's case. I also recommended that future assessments carried out by Rhondda Cynon Taff Local Health Board should clearly set out which criteria the patient is being assessed against and on what basis the eligibility decision has been made.

In making these recommendations, I made no judgment about Mr B's eligibility for continuing NHS funded healthcare, only about the process by which the decision was reached.

Both Powys and Rhondda Cynon Taff Local Health Boards agreed to implement the recommendations.

Cardiff & Vale NHS Trust: Mental Health

Following a manic episode, Mr A was admitted to Whitchurch Hospital on 11 September 2001 under Section 2 of the Mental Health Act 1983 (the MHA). Mr A, who had a bipolar disorder, suffered from delusions that he was a well-known national celebrity and that he was about to become very rich. On 27 September, his detention was confirmed in accordance with Section 3 of the MHA. At this time Mr A was being held on a locked ward. On 5 October Mr A was allowed out of the facility, escorted by a nursing auxiliary, in order to obtain money from a cashpoint machine at his local bank. However, whilst at the bank he arranged a loan for £2000. Later, while under the care of a consultant psychiatrist at the hospital, he arranged other credit facilities. The following month, Mr A's mother received a telephone call from him, whilst he was at a local nightclub. Mrs A later spoke to the Consultant Psychiatrist (the Consultant) responsible for Mr A's care and expressed her concern to him that Mr A was being allowed out when he was still ill. On 30 November a Mental Health Tribunal refused to discharge Mr A because of 'a bipolar affective disorder as exhibited by ... unrealistic, grandiose plans'. The Tribunal also commented that 'leave has only been introduced very recently and needs to be tested out whilst gradually being increased'. Later, Mrs A learnt that her son had been allowed home to his flat on unsupervised overnight leave on numerous occasions, while he was still under section. Following his discharge from Section on 8 January 2002, Mr A became depressed and had to deal with the consequences of his significant and reckless overspending which had taken place whilst he was detained under section. Unable to discharge the debts he built up, he was declared bankrupt. Mrs A complained to the Trust about its lack of care for Mr A and remaining dissatisfied with its response, complained to me.

I received advice from four professional assessors in the field of psychiatric nursing and psychiatric medicine. I expressed concern about the fact that a situation could be allowed to arise whereby a patient with a severe mental disorder is able to secure a loan, in person at a bank, whilst on nurse escort from a secure ward.

That said, I did not criticise the nursing auxiliary's actions in this situation since interviews with Trust staff indicated that they have significant concerns about their powers to intervene in such a situation and moreover the Trust did not appear to have specific guidance available to staff at the time to enable them to act with confidence in such a situation. I found that upon Mr A's return to the ward the incident was appropriately considered by nursing staff and that appropriate action was initiated. However as a result of a breakdown in communication, information about Mr A's visit to the bank was not conveyed to the Consultant in charge of Mr A's care. I found that the breakdown in communication which took place, whilst explainable in the context of the pressurised ward environment, was unacceptable. I found that it was impossible to determine with any degree of certainty that any single individual was responsible for the failure to communicate.

I also considered the frequency and duration of the leaves of absence Mr A was granted by his consultant. I took account of the advice provided by my Professional Assessors that the management of a patient's mental condition involves a fine balance between restricting a patient's movements for their own well-being and allowing the patient a degree of freedom from what is essentially a poor and disturbed environment and thus obtaining the patient's co-operation and goodwill. However it was clear that while under the care of the consultant psychiatrist, unescorted leave was granted leave on a regular and increasing basis. During this period, I established Mr A was taking the opportunity to spend recklessly on these occasions, while still clearly delusional as evidenced by his medical records and other evidence.

My Professional Assessors told him that a typical risk associated with hypomania such as Mr A's is that of recurring serious debt through reckless spending. I agreed with the Assessors' view that one of the aims of admitting a patient such as Mr A to a hospital is to minimise such risk. I also agreed with my Assessors' view that proper risk assessments were not made in Mr A's case, and that when overspending occurred appropriate action was not taken to prevent it. The Assessors expressed the view that there was communication failure between the nursing and medical staff and that the consultant psychiatrist was not clear about his powers to intervene.

I was very mindful of the comments made by my Assessors that these events occurred within a poor environment with over-stretched staffing : within that context the care provided to Mr A by the staff was good and that there was a thoughtful regime for managing a very serious illness. I expressed great sympathy for the Trust's staff and acknowledged their dedication to their patient's wellbeing. I did, however, conclude that, as a result of the numerous shortcomings identified, the Trust failed to provide Mr A with the care he could reasonably have expected to receive whilst a patient detained at the hospital.

The Trust agreed to provide additional guidance and training to its staff on how they should deal with financial matters in relation to their responsibilities under the Human Rights Act towards patients held under the Mental Health Act. The Trust also agreed to implement an enhanced policy on clinical supervision; to clarify the role of the named nurse responsible for overseeing patient care; to properly assess a patient's social circumstances upon admission and prior to discharge and to adapt leave forms to allow greater control of a patient's movements. Finally the Trust agreed to apologise to Mr A and to pay him £2000 as redress for its failure in care towards him.

Gwent Healthcare NHS Trust and the National Assembly for Wales: Accident and Emergency

Mrs A complained that her father, Mr B, was admitted to the Accident and Emergency department of Royal Gwent Hospital at 5.11am on 5 February 2003 complaining of severe abdominal pain. He was assessed by a senior house officer and referred to the surgical department. Mr B was reviewed by a surgical SHO at 6.30am, but remained in A&E due to a shortage of surgical beds. He was next seen by a doctor at 5.15pm, who failed to notice that Mr B had not received pain relief or intra-venous (IV) fluids. At 6.30pm, Mr B's observations were taken for the first time since 12.30pm. These were not acted on, despite showing that Mr B's blood pressure had fallen and his pulse was raised. Mr B's observations were taken again by a more experienced nurse at 8.00pm, who then realised that something was wrong. Mr B was transferred to the resuscitation area and seen by a surgical registrar, who diagnosed a perforated ulcer. An operation to repair this was carried out, but Mr B's condition deteriorated and he sadly died on 7 February 2003.

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Mrs A along with other members of her family wrote to the Chief Executive of the Trust on 24 February 2003 to complain about the standard of care their father had received. Mrs A was concerned that she did not receive a full reply to her complaint until 22 May 2003, and that there was also a delay in handling her request for a copy of her father's medical records. Following a meeting with representatives of the Trust, Mrs A requested an independent review of her complaint. However, her request for a panel was turned down, after some further delay and after the receipt of two conflicting sets of medical advice.

I found that the standard of care provided to Mr B in the A&E department was well below what should have been expected. Mr B was not seen by a senior surgeon before 9.00pm as a communication failure meant that he was not included on the normal ward round. Fluid and pain relief charts were not written up, and this was not recognised or queried by the nursing staff. I found that the standard of nursing care was unacceptable; observations were not carried out regularly, and when they were, changes were not acted on. There was no evidence to suggest that the nursing staff had alerted the surgical team to Mr B's continued presence in the department, or tried to find him a bed. I upheld the complaint. I recognised that the Trust had taken this complaint seriously and welcomed improvements which had been made. However, I made a number of recommendations to prevent this situation happening again.

With regard to the handling of Mrs A's complaint, I found that this had been subject to delays and poor communication by the Trust. In addition, Mrs A's request for a copy of her father's medical records took twice as long as should have been the case. I upheld the complaint, but made no recommendations as the Trust had already reviewed their handling of the complaint and introduced a number of improvements.

I also upheld Mrs A's complaint about her request for independent review. I found that although the Lay Reviewer did not base his decision not to hold a panel on the two conflicting medical reports he obtained, he did not follow the guidance set down by the National Assembly in turning down Mrs A's request; nor did he make his reasons for not holding a panel clear to Mrs A. I recommended that the Lay Reviewer and Lay Adviser should familiarise themselves with the relevant sections of the Assembly's guidance, and ensure, too, that when considering a case about nursing care, they obtain appropriate nursing advice.

Cardiff & Vale NHS Trust: Clinical Practice

In 2002, my predecessor issued a report on an investigation of a complaint by Mrs B about a number of aspects of the care and treatment she had received from a Community Psychiatric Nurse (CPN). The report upheld many of Mrs B's complaints, but did not uphold a complaint that the CPN, who had seen Mrs B as a patient for over five years, had failed to separate her professional and social roles. Mrs B alleged that the CPN had encouraged her to believe that a friendship existed between them, which would continue after her discharge. However, the CPN had then abruptly withdrawn from the friendship. The CPN had strongly denied that she had led Mrs B to believe that they had had a friendship. Mrs B's complaint was not upheld primarily because, in the absence of any evidence to the contrary, the CPN's account of her actions was felt to be more convincing than Mrs B's. However, in early 2005, Mrs B discovered a sequence of handwritten letters to her from the CPN, which she had forgotten about during the original investigation, and submitted them to me as new evidence in support of her complaint with a request that the investigation be re-opened. These letters were written to Mrs B after she had been discharged from the CPN's care. They contained information about the CPN and her family of a personal nature, and were written in terms that would be used between friends. I agreed to reopen the investigation.

I found that the evidence Mrs B had provided, which was not contested by the CPN, supported entirely her consistent account of the CPN's actions. I considered that the CPN had overstepped the necessary boundaries which constitute a professional-patient relationship and would understandably have encouraged Mrs B to view the nature of their relationship as 'friendship'. I concluded that the CPN had failed to adequately separate her professional and social roles. I concluded there was sufficient evidence to indicate that the CPN had previously lied about the nature of her relationship with Mrs B. I upheld the complaint.

I recommended that the Trust apologised to Mrs B for the inappropriate clinical practice of the CPN, and that they audit the CPN's practice to ensure that she was fit to practice safely. I also asked the Trust to take measures to satisfy themselves that the education, training and continuing professional development of its CPNs was appropriate to ensure they were fit to practice, and that robust performance review processes were in place to monitor the activity of clinical staff.

Flintshire Local Health Board: General Practitioner – removal from practice list/complaint handling

Mr and Mrs A complained that they had been removed from the patient list of their GP practice without any prior warning being given, and that their subsequent complaint about this was not dealt with in accordance with the NHS complaints procedure.

Mr A visited the Practice to query a prescription on behalf of his wife. When Mrs A saw her GP a few weeks later for a routine consultation, the GP acknowledged that an error had been made and apologised. Mrs A accepted the apology and felt that the matter was now closed. A few days later, Mr and Mrs A received a letter from the practice, dated the day that Mrs A saw her GP, stating that there had been "an irretrievable breakdown" of the doctor-patient relationship and that "it will be necessary to remove the family from this ... list." Mr and Mrs A were advised to contact the Local Health Board to arrange to register with a new GP.

Mr and Mrs A subsequently made a complaint to the practice via the local Community Health Council (CHC). The Practice Manager's response to the complaint explained that the family had been removed due to Mr A's "abusive and volatile" behaviour when he queried the prescription, and because the practice understood that Mr A had been criticising them in a local chemist's shop. The letter also stated that the GP had suggested to Mrs A during their consultation that an apology from Mr A would have been appreciated; however, Mrs A denies being asked this.

Mr and Mrs A were unhappy with this response and the CHC wrote to the practice again seeking further clarification. In reply, the Practice Manager stated that the practice felt that the correspondence could go on "for ever and a day", and suggested that if Mr and Mrs A wished to pursue the matter further, they should engage a solicitor. Mr and Mrs A then requested an independent review of their complaint. The Lay Reviewer referred the matter back for further local resolution; however, the practice did not feel anything more could be achieved by that.

The new General Medical Services Regulations (Welsh Statutory Instrument 2004 No. 478) implementing the new GP contract, which came into force in April 2004, place a new obligation on GPs to give patients a warning in most circumstances before any final decision is made to remove them from the practice list. The Regulations also require that an explanation be given to patients when they are removed; however, they allow that it is sufficient to state that there has been "an irretrievable breakdown" in the relationship if, in the reasonable opinion of the GP, it is inappropriate for more detailed reasons to be given.

The Practice Manager told my investigator that the practice had not removed the family from the list; they had removed themselves by registering with another GP in response to the practice's letter. She argued that the letter was meant to act as a "warning" as required by the Regulations, and that the decision may have been reconsidered had Mr A apologised for his alleged behaviour.

I found that the practice had failed to act in accordance with the Regulations in removing Mr and Mrs A from their list. I concluded that the letter sent to the family could not reasonably be open to interpretation as anything other than a final decision. I noted that while Mr and Mrs A had indeed technically removed themselves from the list, it was clear that they only did so in response to the practice's letter.

I also criticised the way Mr and Mrs A's complaint was handled by the practice. I felt the second letter sent by the Practice Manager was not a constructive way of addressing Mr and Mrs A's concerns; nor were Mr and Mrs A informed of their right to request an independent review of their complaint.

The Practice agreed to apologise to Mr and Mrs A and to review the way it dealt with removals from the Practice list and complaints.

Further summaries are available on my website: www.ombudsman.wales.org.uk

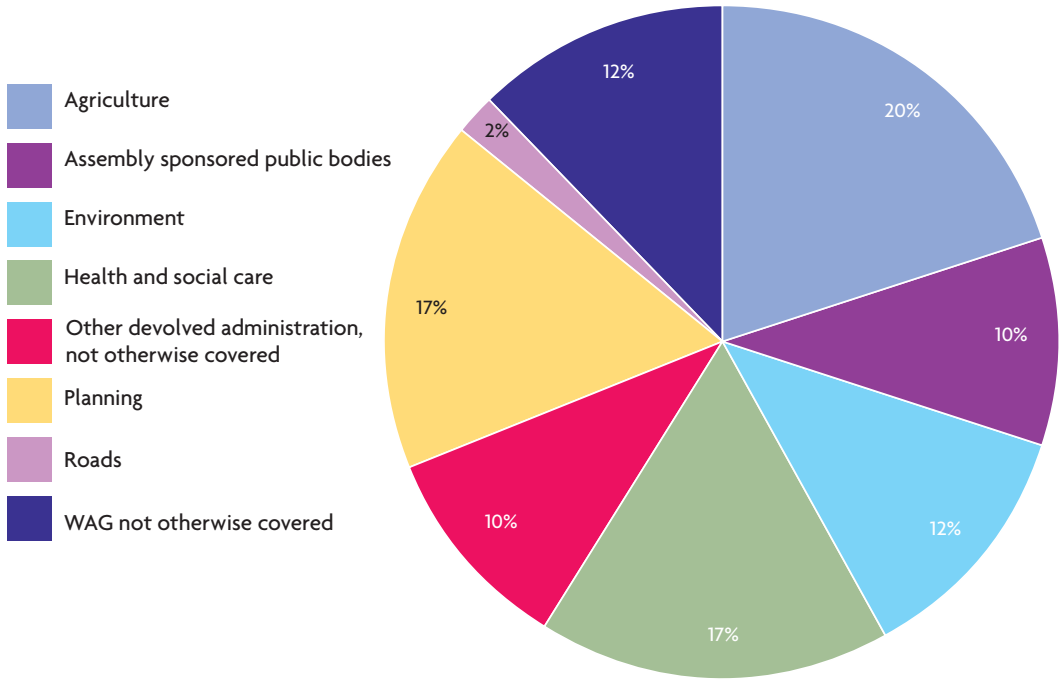
6 Report of the Welsh Administration Ombudsman

As Welsh Administration Ombudsman, I investigate complaints from members of the public that they have suffered injustice because of maladministration by the National Assembly for Wales or certain Assembly Sponsored Public Bodies (ASPBs)

6.1 Overview and Statistics

The number of complaints that I received during 2005/06 was 45, compared to 42 in 2004/05. It is pleasing to see that the number of complaints I receive as Welsh Administration Ombudsman remain fairly low. As the table opposite shows, the majority of the complaints were in relation to the National Assembly for Wales. However, given the wide scope of the Assembly's responsibilities this is to be expected.

As far as the nature of the complaints received is concerned, details are shown below. As can be seen, agriculture, planning, and health/social care were the main areas for complaint.



Public Body	Total Complaints (b/fwd and new in year)	Out of jurisdiction	Premature	Discontinued	Settlement (quick fix)	Settlement	Report Issued (not public) – upheld	Report Issued (not public) not upheld	Remaining Open as at 31/3/06
Arts Council for Wales	1								1
Environment Agency	1	1							
National Assembly for Wales	60	9	9	11	2		9	1	19
The Forestry Commissioners (for matters relating to Wales)	1					1			
Welsh Development Agency	1	1							
TOTAL	64	**11**	**9**	**11**	**2**	**1**	**9**	**1**	**20**

6.2 Case Summaries

The Welsh Assembly Government: Planning Inspectorate for Wales

Mr M complained that the Planning Inspectorate for Wales, acting on behalf of the Assembly, failed to advise him of a Planning Inspector's decision in respect of an order made under the Highways Act 1980, and as a consequence he was denied the opportunity to challenge that decision. Mr M also complained about the handling of his subsequent complaint by the Inspectorate.

In 2002, my predecessor began an investigation into a previous complaint by Mr M that the Inspectorate had failed to send him a copy of a decision letter on a Planning Appeal when it was issued, which he had requested at the public inquiry to consider the appeal. It was not until Mr M enquired as to when the decision was likely to be issued, that he was told that the decision had already been issued and was then sent a copy of the decision letter. Mr M complained that he had thus been denied the opportunity to challenge the decision within the six-week period allowed for a statutory appeal.

The Inspectorate undertook to amend their administrative procedures in order to avoid a recurrence of the failings identified in the case. The Inspectorate recognised that Mr M had lost his right of statutory appeal and that the only avenue open to him to challenge the decision was by way of judicial review. The inspectorate therefore agreed that, should Mr M choose to pursue the matter by way of judicial review and be unsuccessful, they would not seek to recover costs additional to that which would have been incurred by way of statutory challenge. The Chief Planning Inspector also undertook to apologise personally to Mr M for the Inspectorate's maladministration. As a result of the Inspectorate's undertakings, my predecessor felt able to close the investigation, without producing a formal report, on 26 November 2002.

Then, Mr M attended another a public inquiry in respect of a different planning application in which he was an interested party. Again Mr M registered wish to receive a copy of the decision. Having heard nothing further, Mr M telephoned the Inspectorate to enquire when he was likely to receive the decision . It transpired that yet again Mr M had not been sent a copy of a planning decision. Mr M wrote to the Inspectorate to make a formal complaint about the failure to issue the decision letter,

and that the 6 week statutory period allowed for a challenge to the decision had been exceeded. He also questioned the adequacy of the assurance previously given to him in 2002 by the Chief Planning Inspector.

It is incredible, as the Inspectorate itself recognised, that Mr M should have had cause to complain for a second time that the Inspectorate failed to issue him with a copy of a Planning Inspector's decision when he had requested one, and when he was therefore entitled to believe that he would receive it. The fact is it did.

At the time of the first complaint, the Inspectorate assured both Mr M and my predecessor that they had put measures in place to prevent a recurrence. I have seen that those measures were carried out. Having reviewed the evidence in relation to this second incident, it is clear that the actions taken by the Inspectorate following the 2002 case were flawed and merit my criticism.

The Assembly and the Inspectorate readily acknowledged the errors that were made in this latest incident. The Assembly and Inspectorate told me of the measures they have now taken in respect of the Rights of Way team to ensure that a similar mistake does not occur again. However, I recommended that the Inspectorate monitor the effectiveness of these procedures on a periodic basis, to ensure that they are complied with in practice.

Mr M told me that while he was satisfied with the action taken by the Inspectorate in the immediate aftermath of discovering the error, he was extremely dissatisfied with how his letter of complaint had been handled. I recommended that the Inspectorate review the wording that is used in such letters so that they accurately describe the role and accountabilities of the Complaints Officer.

Mr M and the others who asked for a copy of the decision letter were actively disadvantaged by the failure to send it to them. I recommended that a consolatory payment of £250 be made to Mr M, who had experienced repeated maladministration by the Inspectorate.

The National Assembly and the Inspectorate accepted my recommendations and gave their renewed apologies to the complainant for these shortcomings.

National Assembly for Wales: Care Standards Inspectorate

Ms Y was concerned about the care her uncle received whilst at a nursing home. Accordingly, she wrote jointly to the Care Standards Inspectorate for Wales (CSIW), the local authority responsible for the area in which the nursing home was located, the NHS Trust from which her uncle was discharged to the home and the nursing home itself. This letter was acknowledged by the CSIW and Ms Y was told that an investigation of her complaint would take place. Ms Y was dissatisfied about the way her concerns were handled by the Inspectorate and thus complained to me.

As a result of my investigation, I saw no evidence that the CSIW did not adequately investigate Ms Y's complaint. It is part of the Inspectorate's obligation to undertake one announced and one unannounced inspection each year in respect of all care homes. The purpose is to determine whether the registered provider is meeting the requirements of the Care Homes (Wales) Regulations 2002. However, in addition to these inspections the CSIW, as a result of other complaints about the care home in question, undertook six additional monitoring visits and ten scheduled meetings with senior staff at the home between July 2003 and June 2004. As such, the Inspectorate was actively involved in dealing with concerns about the quality of service at the home. My inspection of the CSIW's files clearly showed that they were in regular contact with the relevant local authority social service's department over concerns about standards at the nursing home and that they were undertaking regular monitoring activity.

However, I did find evidence that there were unacceptable delays in the CSIW's investigation. These were partly due to problems in relation to inter-agency co-operation in resolving multi-agency complaints such as this. The CSIW had also been remiss in failing to keep in touch with the complainant throughout the investigation process, which I believe led Ms Y to the view that her complaint was not being taken seriously. These failings had been recognised by the Chief Executive of the CSIW, who had already personally apologised to the complainant on the Inspectorate's behalf for the delay in the investigation and the poor communications from the Inspectorate.

The Permanent Secretary at the Welsh Assembly Government had repeated those apologies and set out the measures taken by the Inspectorate to ensure that complaints were now handled in accordance with the Inspectorate's complaints handling procedure.

I considered that this was an appropriate remedy and hoped that the complainant could now be reassured that the Inspectorate's investigation of her complaint was adequately robust. I therefore closed the investigation at this point, and upheld the complaint about the Inspectorate's handling of the complaint only.

7 Report of the Social Housing Ombudsman for Wales

I became Social Housing Ombudsman for Wales on 15 July 2005. Prior to this the Housing Directorate at the Welsh Assembly Government considered complaints about registered social landlords. Providing that a problem occurred on or after 15 July 2005, I can look into matters such as a complaint by a housing association tenant about a failure on the part of their landlord – for example, in relation to the management of their home. Other members of the public may also have a right to complain about a social landlord if they are personally affected by their actions of failure to act. An example might be if a person lived close to a property owned by a social landlord and they felt that they were personally suffering as a result of the landlord's failure to manage the property effectively.

7.1 Overview and statistics

Details of the complaints I have received about registered social landlords since 15 July 2005, are set out on the following pages.

Registered Social Landlord	Total Complaints (b/ fwd and new in year)	Out of jurisdiction	Premature	Discontinued	Settlement (quick fix)	Settlement	Report Issued (not public) - upheld	Report Issued (not public) not upheld	Remaining Open as at 31/ 3/ 06
Bro Myrddin	1			1					
C C H A	1	1							
Cadwyn Housing Association	1								1
Cardiff Community	1	1							
Charter Housing	1								1
Charter Housing Association Ltd	1			1					
Family Housing Association (Wales) Ltd	1			1					
Glamorgan and Gwent	1		1						
Gwalia Housing Trust	1	1							
Gwerin (Cymru)	2		1	1					
Hafod	1								1
Newport Housing Trust	1								1
North Wales	1	1							
Rhondda	1								1
Rhondda Housing Association	1								1

Registered Social Landlord	Total Complaints (b/ fwd and new in year)	Out of jurisdiction	Premature	Discontinued	Settlement (quick fix)	Settlement	Report Issued (not public) - upheld	Report Issued (not public) not upheld	Remaining Open as at 31/ 3/ 06
Taff Housing	1	1							
Tudball & Edwards	1								1
United Welsh/United Welsh Housing Assoc	3		2						1
Valleys to Coast	4		1				1		2
Wales and West	3	1	1	1					
TOTAL	28	6	6	5			1		10

7.2 Case Summary: Valleys to Coast Housing Association

Ms A was nominated to Valleys to Coast for rehousing by the Council on the basis that she was homeless. Ms A was contacted concerning a property but, before an offer was made, Valleys to Coast discovered that she had previous criminal convictions from a former Council tenancy. Ms A's nomination was therefore refused. She was not given an explanation as to why her nomination had been refused nor was she informed of any right to appeal.

It appeared that the nomination agreement between the Council and Valleys to Coast gave the Council the right to appeal nomination decisions, though nominees themselves did not have this right. Applicants who applied directly to Valleys to Coast for rehousing were given a written explanation and a right of appeal of any decision to suspend or exclude them from the housing allocation list. Ms A had in effect been excluded from rehousing by Valleys to Coast without following its own exclusion procedure.

I upheld the complaint. Valleys to Coast agreed to give Ms A a written explanation as to why she had been excluded and inform her of her right to appeal. Valleys to Coast also agreed to alter the anomaly in the nomination agreement to ensure that those nominated for rehousing were able to appeal any decision to exclude or suspend them from the rehousing list.

Appendix

Performance against Corporate Plan 2005/06

This year has been a challenging but on the whole very successful year. The major aim was to achieve a successful re-organisation in respect of the Ombudsmen public service ombudsmen schemes in Wales; whilst avoiding disruption to our day-to-day activities of investigating complaints.

This meant a great deal of work preparing for the introduction of the new office and the abolition of the existing offices of the Commissioner for Local Administration in Wales; the Welsh Administration Ombudsman; the Health Service Commissioner for Wales; and the Social Housing Ombudsman for Wales on 31 March 2005. The aim was a seamless transition.

I was appointed by HM The Queen as Public Services Ombudsman for Wales in October 2005. As a result of this and being previously appointed to each of the existing Ombudsman offices, I was able to get the process of planning and implementing an improved service which would offer citizens a 'one-stop shop' well underway.

The past year has seen significant activity in implementing new methods of service delivery, including a new complaints procedure and new information technology systems. My corporate plan for last year set out a number of key activities mainly related to this work of transition and I report here on the outcome against targets set.

Target	Outcome
1. Legislation:	
(a) Public Services Ombudsman for Wales (PSOW) Act - Ensure that all necessary arrangements are in place by the date that the Act comes into force to facilitate smooth transition from existing Ombudsmen schemes to the new unified Ombudsman scheme.	Achieved. All arrangements were in place at 31 March 2006.

Target	Outcome
(b) Social Housing Ombudsman for Wales – Prepare for undertaking this role in respect of housing associations should the relevant legislation come into force before the PSOW Act.	Achieved. Discussions with National Assembly resulted in transitional arrangements being in place for the date (15 July) when PSOW took on responsibility for complaints about housing associations. Information literature also pre pared and widely distributed.
2. Staffing:	
(a) Review the effectiveness of the new staffing structure	Review of investigation/assessment work resulted in further recruitment for the assessment unit and the creation of another tier of management under Director level.
(b) Consider what developments need to take place in relation to 'other' functions, such as human resources, etc	Interim arrangements in place during 2005/06. Delivery of the human resources function will need further consideration in 2006/07.
(c) Continue with the work on harmonizing terms and conditions	New terms and conditions agreed with trade unions and staff invited to sign new contracts.
(d) Implement arrangements for dialogue with staff representatives.	The Staff Representative Council has now been formed and first meetings held.
3. Training:	
(a) Legislation – Complete appropriate training so that staff are able to consider complaints in line with the new PSOW legislation.	All relevant training completed by 31 March 2006.

Target	Outcome
(b) Case Management System – Assess whether further staff training is required in relation to the new system introduced in March 2005.	All relevant training completed by 31 March 2006.
4. Assessment Unit:	
(a) Continue to develop the new unit established. To support this, arrange for a secondment to the team of an experienced member of staff from another public services Ombudsman scheme.	Much development has taken place over the past year. A secondment from the Scottish Public Services Ombudsman was arranged and proved particularly useful. This demonstrated the need for a full time post of Assessment Unit Manager, which has now been created and filled.
(b) Aim to reduce time taken to first assess whether a complaint can be investigated to two weeks.	It was been determined that two weeks is an unrealistic target. The target for 2006/07 will be: 90% within 3 weeks; and 100% within 6 weeks.
5. Investigation Teams:	
(a) Further harmonise and develop common complaints procedure introduced (b) Carry out post implementation review of the case management system	A case management review group was established. A number of changes have been made to the system and a revised complaints procedure has been introduced.
(c) Consider what steps should be taken to reduce the backlog of cases	Backlog addressed (this included recruiting an ex-investigator on a temporary basis).

Target	Outcome
(d) Consider what practices could be put in place to speed up the process of investigating cases (but this not to be at the expense of the good quality, thorough investigations, currently being undertaken).	Decision taken to recruit additional assessment officers (see 2(a) above). Measures also taken to speed up the assessment process. As a result of this, all complainants will benefit from a speedier outcome, regardless of whether their case is progressed to full investigation or not.
6. Corporate Services:	
(a) Complete integration of finance function of the three existing schemes, particularly those aspects currently undertaken on behalf of the Health Service Commissioner for Wales by the Parliamentary and Health Ombudsman service in London. Also need to make provision for Social Housing Ombudsman for Wales service.	Integrated finance function achieved.
(b) Produce regular budget monitoring reports for consideration by the Senior Management Team	Monitoring reports now being produced monthly for management team meetings.
(c) Complete assessment and identification of any improvements/adjustments that need to be made to the working environment following the move to new offices in March 2005.	An external health and safety consultant was appointed and a full workplace assessment has been carried out. No significant issues identified. Individual workstation assessments have been completed and issues identified have been addressed and responded to. Environmental issues such as noise have also been addressed and remedied.

Target	Outcome
7. Performance Standards:	
(a) Performance Indicators – Establish appropriate and robust targets to assess the quality of the service we provide	Consideration of monthly performance monitoring reports together with comparison of targets set by other Ombudsmen schemes have resulted in robust performance indicators being set for the new organisation.
(b) Management Information Data – Appraise whether the new case management system provides the desired level of information.	Management data continuing to develop, but to date the case management system is able to provide the type of information desired.
8. Publicity and Outreach:	
(a) Hold a launch for the day that the PSOW Act comes into force, to include associated media and press attention.	It was agreed that the Welsh Assembly Government would launch the new office of Public Services Ombudsman for Wales – to take place in May 2006.
(b) Prepare a programme of outreach activity for the second half of the year	Following the mass distribution of new information leaflets throughout Wales in the first half of the year, outreach activity for the second half of the year concentrated on senior management and staff undertaking a number of speaking engagements; there were also a number of television appearances by the Ombudsman on Welsh current affairs/ news programmes.

Target	Outcome
(c) Develop the new website further so that a higher level of information is available.	The second phase of the website development was completed in December. This now offers a greater degree of information than was previously the case.
9. Other Ombudsman Schemes: (a) Review the service level agreement between PSOW and OPHSC (b) Continue with developing relationship with other schemes to share issues of best practice.	 Completed. Attendance at various BIOA and public service ombudsmen meetings continues as well as visits to individual ombudsmen offices in UK. It was also pleasing to be able to host a meeting of the Public Sector Ombudsmen at our new offices at Pencoed in October 2005.
10. Good Practice Guidance: Identify: areas where guidance to the bodies within the PSOW jurisdiction needs to be issued.	A joint working group has been formed with the Welsh Local Government Association, with a view to issuing guidance in relation to complaints procedures for local government in June/July 2006.
11. Accountability to the Public: Develop policies/plans to ensure that PSOW will be compliant with various legislation such as: Freedom of Information Act; Equal Opportunities Acts; Welsh Language Act	Policies/plans in place except where working to timetable of the Information Commissioner and the Welsh Language Board in respect of plans to be approved by these bodies.

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