

**Equality &
Human Rights
Casebook**

2019/20

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Foreword

It gives me great pleasure to present the first casebook focused on cases I have dealt with that have a human rights or equality element to them.

In all these cases, human rights matters have either been expressly raised as part of the complaint or have been pivotal to my findings.

Public bodies in Wales are rightfully expected to consider the human rights of users, both in planning services and delivering them.

Where I find evidence that a failure in service has directly caused an injustice, it is appropriate for me to consider whether a person's human rights were compromised.

For many years I have published a casebook containing summaries of all investigation reports issued during the previous quarter, as well as a selection of summaries relating to complaints settled as an alternative to an investigation (known as voluntary settlements).

Many of those have dealt with the FREDA principles (Fairness, Respect, Equality, Dignity and Autonomy) and broader equality and human rights matters. Championing the FREDA principles (particularly fairness and dignity) has been implicit in the core work of Ombudsman schemes across the globe, and here in Wales is no exception.

More recently, I have made explicit reference to specific human rights Articles in appropriate cases. Those Articles derive from the European Convention on Human Rights (ECHR). These have since been enshrined in UK law by the Human Rights Act 1998.

Over the past two years, my investigative team has placed greater emphasis on exploring equality and human rights considerations when dealing with complaints.

While I have previously prepared summaries for internal purposes, to support our focus on equality and human rights, this is my first casebook for external publication.

Express findings of a breach of any relevant laws are not matters for me, but the Courts. However, by outlining the thinking behind these decisions, I hope to demonstrate the approach I take and the continued importance of equality and human rights considerations in the work of my office.

As Ombudsman, I must promote and help protect the human rights of ordinary people in their dealings with public service providers in Wales. This is a duty my office will continue to uphold with determination.



Executive summary

This Casebook includes 11 cases where I found that public bodies failed to consider or safeguard the human rights of service users.

Of these cases, three resulted in the issue of public interest reports under section 16 of the Public Services Ombudsman Wales Act 2005.

Eight of the cases led to the issue of non-public interest reports under section 21 of the same Act.

I also outline four complaints where settlements were reached as an alternative to full investigation. These cases show that organisations can change for the better when they make mistakes, but only - in my experience - where there is a culture of transparency and continuous improvement.

Of the cases included here:

- 6 involve complaints against Health Boards
- 7 involve complaints against a Local Authority
- 1 involves a complaint against a Housing Association
- 1 involves a complaint against a Police and Crime Commissioner's office

The cases cover a range of topics, including:

- Mental health services
- End-of-life care
- Social services and care home funding
- Maternity care
- Failure to comply with duties under the Equality Act when decision-making

Some examples of the cases featured include:

- The case of Mr B, whose 11-year-old son waited two-and-a-half years for urgent paediatric renal surgery. This unacceptable delay in treatment had a significant impact on the boy's quality of life, causing much stress and upset to both him and his family. The Ombudsman found maladministration in the way that the two Health Boards involved dealt with C as a patient. He found that the delay endured was sufficient to engage Article 8 of the ECHR (the right to respect for private and family life).

- The case of Mrs X, where the care provided at the end of an elderly woman's life was judged to be "detrimental", both to her well-being and the manner of her death. The patient sadly died on a trolley waiting for a bed, meaning her family were unable to spend their final hours with her in a quiet space. The Ombudsman found that Mrs X's human rights were "likely to have been compromised", again under Article 8, because her dignity at the end of her life was not respected.
- The case of Mr A, a devout elderly Sikh with dementia, whose beard and facial hair was trimmed by a member staff in hospital. The family said that they, and Mr A, were distraught to discover this and that it was an act of religious violation because Mr A had never cut his beard, in line with strict Sikh observance. The family felt this religious violation contributed significantly to his decline, as Mr A passed away some days later. The Ombudsman found that the several aspects of Mr A's human rights were affected - Article 3 (degrading treatment), Article 8 (right to respect for his private and family life) and Article 9 (right to manifest his religion).

I also include three cases where complaints were not upheld as I believe these to be instructive for public bodies.

Background

The Human Rights Act 1998 incorporates into domestic UK law the rights and freedoms as set out in the ECHR. Some are **absolute** rights, meaning that the citizen should be free to enjoy them, and the state can never interfere with that. There are some **limited** rights, meaning they might be interfered with in certain circumstances (such as times of war or emergency). Finally, others are **qualified** rights, meaning that the state can legally interfere with them in certain situations – e.g. to protect the rights of other citizens. The most common rights featured in the complaints considered by my office are the following:

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

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

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

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

Article 5 - This is the right to liberty and security - **a limited right**

This article can apply when an individual is detained in some way – i.e. are not free to leave. Consideration is given to the context and law – e.g. a person may lawfully be deprived of their liberty following a conviction and sentence by the courts.

In mental health or care home settings, we would consider the procedural safeguards put in place before any detention takes place, such as due process under the Deprivation of Liberty Safeguards. Has the individual been able to challenge that decision – e.g. access to the Mental Health Review Tribunal?

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

The right to a fair trial relates to decisions about civil rights or in dealing with a criminal charge. Public bodies should meet this requirement too in their complaints handling processes in terms of procedural fairness. Has the public authority provided a reasoned decision, so someone knows the basis for it and can decide whether to challenge it further (by any appeals process)?

Does the composition of a decision body/panel ensure fairness and impartiality? A right to a public trial can be restricted if the exclusion of the public is necessary to protect certain interests or if there is a right to progress to a court of tribunal that complies with that requirement.

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

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

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

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

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

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

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

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

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Cases

Public interest reports issued under s16 PSOW Act 2005

201703374 [Health - mental health services]

Cwm Taf University Health Board

Mrs A complained that the Health Board had delayed in providing her son, Mr B, with timely mental health and autism spectrum disorder (ASD) assessments. Mrs A said that she watched Mr B struggling to function for many years, as he sunk deeper into depression and attempted to take his life. Despite this, there were continual and lengthy delays in his assessments.

The Ombudsman found that the Health Board overall had failed Mr B by not properly assessing him in a timely way and so failing in the management of his risks and crisis. The care fell short of the national standards expected. The Ombudsman commented that Mr B's human rights (Article 8) were relevant in this case and that it was appropriate for him to consider if those rights were compromised. He said:

“Mr B was a vulnerable individual, his needs and wishes should have been properly considered by the Health Board and he should have been treated with fairness, respect, equality, dignity and autonomy...”

“Mr B suffered the indignity of not having a family life, or indeed any apparent quality of life...I consider that Mr B's Article 8 rights have been engaged, as a consequence of the failings identified in this report. This resulted in uncertainty, and Mr B suffered the indignity of living in a state of isolation, blocking out the world and with limited quality of life, during this time.”

The Ombudsman recommended that his report be referred to the Health Board's Equalities and Human Right team, to identify how an individual's human rights could be further embedded into its mental health practices and procedures.

201701479 & 201702267 [Health - paediatric renal case]

Cardiff & Vale University Health Board AND Hywel Dda University Health Board

Mr B complained that his son C (who was 11 years old) had waited two and a half years for urgent paediatric renal surgery. He said that this was an unnecessary wait and had a significant impact on C's quality of life. During this time, C had suffered frequent infections, requiring antibiotics, and an open wound on his side needed dressing three times a week. C was unable to do things he enjoyed with his friends like playing football or swimming, as he could not do any contact activities. This had been stressful and upsetting for C. There was evidence that C had failed to thrive during this time.

The Ombudsman found maladministration in the way that both Health Boards involved had dealt with C as a patient, and that the delay in waiting for his surgery was unacceptable. The Ombudsman also noted that the impact on C of his debilitating condition at the time was significant. He commented that central to applying human rights in practical terms was the recognition of a patient as an individual and the delivery of care appropriate to their needs. The Ombudsman noted that Article 3 (inhuman and/or degrading treatment) and Article 8 (right to private and family life encompassing dignity) were relevant to consider in this case. The Ombudsman felt that the length of wait endured by C was sufficient to engage Article 8, having already found the wait to be unacceptable. While acknowledging that the test set by courts for engaging Article 3 is high and that on balance it was probably not engaged in this case, the Ombudsman said that it was a finely balanced issue. He commented that his findings overall in the case made it very serious; hence, it was of public interest.

201603927 [Health - elderly end of life care]

Betsi Cadwaladr University Health Board

Mr Y complained about the care his mother (Mrs X) had received after admission to hospital when she was very ill. The family had agreed that Mrs X should not undergo any interventions but receive supportive care for comfort and quality of life only. Despite this, Mrs X was twice transferred to a different hospital for a scan. On the second occasion (after a 22-mile journey), there was no bed for her on arrival. Consequently, she, sadly, died on a trolley waiting for a bed.

The Ombudsman found that Mrs X had been unnecessarily moved given the proposed scan would not have altered the approach to her care. He said that the second journey, when Mrs X was approaching the end of her life, was detrimental to Mrs X's well-being and the manner of her death. The family were unable to spend what were her final hours with Mrs X in a quiet space. This impacted on Mrs X's dignity and on the quality of the family's remaining time with her so engaging Article 8. The Ombudsman said that Mrs X's human rights were likely to have been compromised because her dignity at the end of her life was not respected. He also found that there had been a failure to take account of the wider family's needs as enshrined in Article 8. The Ombudsman made several recommendations

about training clinicians in end-of-life care matters as well as asking that his report be referred to the Health Board's Equalities and Human Rights Team to identify how consideration of human rights could be further embedded into clinical practice.

A link to the full copy of each of the public interest reports referred to above can be found here:

[Cwm Taf University Health Board - 201703374](#)

[Cardiff & Vale Health Board and Hywel Dda University Health Board - 201701479 & 201702267](#)

[Betsi Cadwaladr University Health Board - 201603927](#)

Non-public interest reports issued under s21 PSOW Act 2005

201705774 [Social Services and care home funding]

Isle of Anglesey County Council

Mr G complained that the Council declined to fully fund his choice of an alternative placement for his wife, Mrs G, who had dementia. The home she was living in was unable to accommodate her any longer and set a date by which she would have to leave. Mr G complained that the Council failed to assist him in finding a new home for Mrs G that suited her needs and that it only engaged with him four weeks before the home's deadline. He also complained that the Council had failed to re-assess Mrs G's needs or consider the disruption to her of moving to a new care home. It had also failed to consider any consequences to him, as Mr G was in poor health and drove to visit his wife daily.

Accordingly, Mr G found a care home which he felt suited his wife's needs, that enabled him to continue visiting her, and had a vacancy to receive Mrs G by the deadline. However, the new home cost more per week than the level the Council was routinely prepared to fund. Mr G argued that the Council should, in the circumstances, pay the 'top-up' fees.

The Ombudsman found that the Council had failed to engage early enough, or conduct a re-assessment of Mrs G's needs, which was necessary to establish the suitability of any new home placement. He upheld Mr G's complaint. In accordance with the law and government guidance, the Council had therefore not been able to demonstrate that any cheaper residential home met Mrs G's needs. The Ombudsman also commented that the circumstances of the case engaged Mr & Mrs G's human rights (Article 8). The new home's location was integral to both Mr and Mrs G's ability to continue their family life through Mr G's daily visits, which had a positive effect on Mrs G's health and wellbeing.

The Ombudsman was not satisfied that the Council had sufficiently demonstrated consideration of human rights in this case – its actions and lack of assessment suggested otherwise.

The Ombudsman made several recommendations, including that the Council should refund Mr G the ‘top-up’ fees he had already paid and that its social care staff be reminded about Article 8 human rights considerations.

201700388 [Social Services provision]

Gwynedd Council

Mrs X complained that the Council had failed to provide adequate support for her son, Mr A, and had disregarded his needs as a person with Autistic Spectrum Disorder (“ASD”).

The Ombudsman found clear failings in Mr A’s case in that the Council had ignored his care and treatment plan, failed to undertake a proper review of his needs (by ignoring his ASD in the review) resulting in an unjustified cut to Mr A’s support hours. The Council’s actions caused him a significant injustice. They also, in the Ombudsman’s opinion, impacted on Mr A’s human rights (Article 8). However, the Ombudsman felt that his finding of maladministration, in this case, was so clear, and so serious, that to discuss human rights issues further would add little value to his case analysis and outcome.

201707282 [Housing services]

Isle of Anglesey County Council

Mrs A (who was disabled with health problems) complained on behalf of herself and her elderly neighbours. They all lived in designated senior citizen bungalows and complained that the Council had failed to deliver on a proposed scheme to provide dedicated parking spaces for them. That failure was impacting on their daily life and, Mrs A said, impacting on their being allowed to live ‘with dignity’.

The Ombudsman commented that public bodies were required, under the Equality Act 2010, to make reasonable adjustments to their services to address barriers preventing people with a protected characteristic, such as a disability, accessing services. The right to the enjoyment of one’s home and private and family life was governed by Article 8. Although recognising that the provision of parking was not a statutory obligation imposed on the Council, the Ombudsman felt that the evidence demonstrated the Council’s approach, in this case, had been ‘blinkered’. It had not fully considered the impact on Mrs A and her neighbours. Furthermore, it had failed to demonstrate to the Ombudsman (through documentation) that it had paid sufficient regard to its equality duties (of reasonable adjustment) or human rights (of Mrs A’s dignity in the enjoyment of her home).

The Council had also failed to consider the trigger of its statutory homelessness duties in light of Mrs A’s overall situation. It agreed to the Ombudsman’s recommendation to undertake a proper assessment of Mrs A’s situation with these matters in mind.

201708070 [Health – maternity care]

Cardiff & Vale University Health Board

Ms X complained about her care and treatment by the Health Board's Midwifery Team during her pregnancy. She had learnt that information about her had been included in a formal safeguarding referral form, which she had not been told about at the time. Ms X said the information was inaccurate in portraying her as unstable, unsafe and uncooperative resulting in her unborn child being placed on the Child Protection Register. Ms X said that the Health Board, through its actions, had discriminated against her on the basis that she had been diagnosed with Bipolar disorder. The events, Ms X said, had left her traumatised and feeling bullied and stigmatised, feeling forced to agree to certain medical interventions and being denied the opportunity to have a home birth, as she would have wished. She feared her baby might be removed from her because of the referral, and if she did not 'obey' the medical professionals involved. Ms X considered her Convention rights to have been infringed and that she was 'violated and dehumanised'.

As Ms X's complaint had expressly referred to Convention rights and discrimination, the Ombudsman's investigation considered the Health Board's actions with these in mind, while noting it was not for him to make definitive findings of any infringement. He noted the language used by Ms X was the language of Article 3 (torture, inhuman and degrading treatment). However, in line with the approach of courts, he felt it more appropriate to consider Ms X's views through focusing on Article 8 (which encompasses dignity and the right to make personal choices and of self-determination). Article 14 relating to discrimination was also relevant.

During the investigation, the Health Board accepted that its actions in Ms X's case had discriminated against her on the grounds of her mental health. It maintained the referral was, however, necessary to protect her unborn baby and that it was entitled to do so as Ms X's Article 8 right was a qualified right. In noting the Health Board's position, the Ombudsman commented that it had adopted a legally flawed argument. While Article 8 was a qualified right, it did not apply to the baby until the point of birth. The Health Board's actions had taken place before then when only Ms X's Article 8 rights were relevant. Recognising that the Health Board did have safeguarding responsibilities, and in that context it was entitled to consider the best interests of an unborn child, given it had acknowledged some actions had only been undertaken because of Ms X's diagnosis, the Ombudsman accepted that the Health Board had discriminated against Ms X (Article 14).

As well as a number of procedural recommendations relevant to other matters, and making an apology to Ms X, the Ombudsman asked that the Health Board refer the case to its Equalities and Human Rights officer for review and identification of learning particularly on the application of Article 8, as well as identifying learning focused on mental health to ensure no discrimination occurred.

201800160 [Health – end of life care]

Aneurin Bevan University Health Board

Mrs T complained about the Health Board's management of her late mother, Mrs Y's, condition. This included the timeliness of its actions, including her proposed transfer between hospitals and Mrs Y's end-of-life care. Mrs Y died in a hospital even though it was her wish to be at home.

In his investigation, the Ombudsman considered that there was a failure in proper transfer planning in Mrs Y's case. This, along with other failings, compromised Mrs Y's ability to have a dignified death. The Health Board, through the failures identified, denied Mrs Y the opportunity to make an informed choice about her treatment, so causing her additional distress. Had she known that a course of treatment being considered would not, in fact, have been possible, the Ombudsman felt that Mrs Y might well have decided to be discharged sooner. He said that this clearly engaged Mrs Y's Article 8 rights. While not for him to make any finding on the matter, the Ombudsman asked the Health Board to reflect on this issue bearing in mind Mrs Y's express wish to be cared for at home if no active treatment was possible.

201604723 [Equality Act public sector equality duty and decision making]

Conwy County Borough Council

Miss X complained on behalf of a group of services users from the Deaf community about the Council's decision to withdraw funding to a charitable organisation. That organisation provided services to that community. Miss X complained that there had been a failure to consult with the Deaf community or other relevant organisations properly and that there had also been a failure to carry out an equality impact assessment (EIA), as required by the Equality Act.

The Ombudsman's investigation found that there had been a lack of consultation with service users about the planned changes. The funding contract had been in place for many years, and so he felt there was a reasonable, and legitimate, expectation that consultation with the Deaf community about proposed changes would take place. Furthermore, the Council had failed to undertake a full EIA before the end of the funding contract period in advance of making its decision. Therefore, the Ombudsman found that the Council had acted with maladministration and upheld the complaint. He said that the Council had not paid due regard to its public sector equality duty. The Council agreed to the Ombudsman's recommendations, including that it would agree to complete a full EIA and continue provision of the existing service to the Deaf community in the interim period.

201606061 [Social Services – POVA investigation]

Ceredigion County Council

Mrs K complained about the Council's Protection of Vulnerable Adults (POVA) investigation into a referral made against her when she worked at a nursing home. She complained that the Council's investigation had not been conducted or completed in a timely manner. It had taken over a year to complete. Mrs K complained that she had received no explanation for the delay within that period, that the Council had failed to take into account the impact upon her of the delay and she was unhappy with the outcome of the investigation and the handling of her complaint. Mrs K had been unable to work pending the investigation's conclusion as employers were reluctant to recruit her while an ongoing POVA investigation was conducted. She said that it had a devastating effect on her life and claimed that the Council had breached Article 6 (right to a fair trial) in its handling of the matter.

While noting the personnel issues cited by the Council, the Ombudsman upheld the complaint finding that the investigation process (for which there are set timescales) had taken too long in Mrs K's case. The Council had also failed to communicate the personnel issues and the reasons for the delay to Mrs K. It had also not taken proper account of the personal impact on her. The Council was asked to apologise, provide financial remedy and to ensure no recurrence of the failings identified in the case. The Ombudsman noted that the threshold for a finding of breach of Article 6 was high; moreover, it was not a finding for him to make. Nevertheless, he commented that as there were escalation processes in place for dealing with her complaints, ultimately Mrs K had received a fair hearing of her concerns. This included being able to complain to the Ombudsman.

201801288 [Social Services – Special Guardianship issues]

Powys County Council - discontinuation of an investigation by an agreed settlement

Mr & Mrs A complained that the Council had failed to fulfil its statutory duties both during and on the expiry of Special Guardianship Orders relating to two children (X and Y) cared for by Mr & Mrs A. Special Guardianship Orders (SGO) are made by the Family Court, placing a child or young person to live with someone other than their parent on a long-term basis. Financial support and other services from the local authority can be available to people granted an SGO. The SGO plans for X and Y said that they would be entitled to the same financial support as those young people leaving care at 16, 18 and 21 years of age. The Council's Leaving Care Policy said that it would continue to provide financial support for children until they completed their education, or until they reached the age of 24 (whichever came first). However, the Council had ceased financial support for X and Y even though they remained in full-time education and lived with Mr & Mrs A who provided for their needs. Mr & Mrs A also complained that the Council had failed to undertake the necessary reviews of X and Y's plans, that its decision had put the family under financial pressure, and that it had failed to deal with their complaints adequately.

At the beginning of the investigation, the Ombudsman asked the Council to explain to him its rationale for seemingly departing from its policy position in this case. He asked what regard it had given to the engagement of Article 8 (respect for family life) in its dealings with the family. The Ombudsman also requested that the Council comment on what regard it had given to the United Nations Convention on the Rights of the Child. Of particular relevance were Article 3 (the child's best interests must be a top priority in all decisions affecting children) and Article 6 (an authority must do all it can to ensure that children develop to their full potential). The Council asked for some time to consider its position and subsequently offered to resolve the complaint. It agreed to pay Mr & Mrs A the sum of £32,275.00 (representing the financial support for X and Y from the time it had decided to cease it) and to reflect and learn from the failings identified in the case. The Ombudsman discontinued his investigation in accordance with his powers.

Settlements as an alternative to investigation

The PSOW Act enables me to consider resolving a complaint as an alternative to an investigation. This has the benefit of allowing formal recommendations to be made to ensure lessons are learnt as well as a swifter outcome for a complainant.

I can only do so where it is a complaint I could have investigated and will do so in cases I consider appropriate.

The settlement examples featured below were possible because of the early identification and consideration of human rights and equality matters, which was to prove pivotal in enabling the resolution of those complaints.

The first example shows that significant wider learning is possible in some cases where not only is the issue, and a resolution, identifiable early on but also where the organisation concerned is eager to learn from what went wrong, as the Health Board was in this particular case.

201705056 [Health – treatment of a patient with dementia/religious belief]

Aneurin Bevan University Health Board – early settlement

Mr A, an older man with dementia, had been admitted to one of the Health Board's hospitals. Mr A was a devout Sikh. When the family visited him, they discovered that a staff member had trimmed his beard and facial hair. It was said that this had been done, with Mr A's consent, for his comfort when eating. The family said that they, and Mr A, were distraught to discover this and that it was an act of religious violation because Mr A had never throughout his life cut his beard (according to strict Sikh religious observance). They said that no regard had been given to his religious needs to the point where the family felt the act had contributed significantly to his decline. Mr A passed away some days later.

The Ombudsman noted that because of his religious beliefs, diagnosis of dementia and distress at the outcome, it was certain that Mr A was not able to properly consent to the trimming of his facial hair. That act engaged Mr A's following human rights - Article 3 (degrading treatment), Article 8 (right to respect for his private and family life) and Article 9 (right to manifest his religion). The Ombudsman said that what had happened in Mr A's case should not have occurred. It also showed the importance of communicating with the wider family, particularly when the patient has dementia. The Ombudsman resolved the complaint in the following way with several recommendations made to the Health Board for wider learning. These included the following key actions relevant to equality and human rights matters:

- Developing a checklist and resource information for staff likely to have daily interaction with a patient on key interfaith points covering the primary cultures/faiths known from the Health Board's demographic profile.
- Piloting an interfaith learning session for the ward where Mr A had been a patient and then rolling this out to other wards.
- Including that information within the induction training of all new healthcare workers and nursing staff.
- Ensuring vital cultural information (such as in Mr A's case) is clearly recorded in a patient's care plan and records.
- Reviewing the Health Board's Equality & Diversity training plan to ensure the delivery to all staff (seeking specialist advice if necessary) of training covering the following matters:
 - Cultural and religious observance
 - The critical importance of family communication about such matters
 - Human Rights and the ECHR
- Implementing a practice to ensure that the needs of dementia patients were gathered early on admission and communicated to staff who would be caring for the patient.

201605406 [Housing - adaptation /repairs for disabled tenants. Equality Act]

Trivallis (a Housing Association) – early settlement

Ms A had difficulty accessing her home, rented from the Housing Association, with her mobility scooter. The Housing Association had installed a ramp, but the work was carried out so badly that she was unable to access her home with the scooter, affecting her quality of life and independence.

The Ombudsman found that the work undertaken had worsened Ms A's situation as a disabled person. He identified shortcomings in the way that the Housing Association had carried out its adaptations and reminded it of its wider equality duty when it came to meeting the needs of its disabled tenants. The Ombudsman said:

"I am concerned that administrative shortcomings, coupled with internal process failings, have impacted adversely on the Housing Association's ability to fulfil its equality duty properly. Consequently, it seems to me that this case raises concerns, both at an individual level and more widely, in terms of how effectively the Housing Association is meeting the needs of its disabled tenants."

The Housing Association agreed to the Ombudsman's proposed settlement terms that included process changes and a reflection on its equality duty, including what additional measures it might need to implement to ensure compliance with that duty.

201606454 [Education - School Transport]

Swansea Council

Mrs X complained that the Council had not provided her 11-year-old daughter, who had autism (a protected characteristic under the Equality Act), with free school transport. It was alleged that the Council had failed to have due regard to the daughter's disability and her specific needs.

When asking for comments on the complaint, the Ombudsman included a specific question in the investigation start letter. He asked: *What consideration did the Council give to their responsibilities under the Equality Act in reaching its decision (given the protected characteristic)?*

The Council volunteered a settlement, and the investigation was discontinued based on the Council's actions:

- The Council held a new Panel to consider these equality issues in relation to Mrs X's transport request for her daughter.
- The Panel recommended that transport be provided based on the child's age, disability, individual circumstances and the availability of a safe walking route to school.
- The Council's agreed to review its Home to School Transport Policy in light of the Panel's consideration of the issues in the case.

201704744 [Complaint Handling – Equality Act]

Dyfed Powys Police and Crime Commissioner – early settlement

Mr T has a disability affecting his ability to communicate. He communicates in complex emails which he considers straightforward but which to other readers can be hard to follow. The Commissioner insisted on Mr T completing a form with his complaint/concern about the Chief Constable. Mr T believed he had already provided the relevant information in his emails and complained that the Commissioner had failed to make a reasonable adjustment for his communication needs. He also complained that the Commissioner failed to respond to his complaint about the Chief Constable and failed to respond to his complaint about the Commissioner's service.

The Ombudsman considered that the Commissioner had failed to acknowledge or respond to Mr T's request for a reasonable adjustment. The Commissioner should have considered how to communicate effectively with Mr T and whether the reasonable adjustment was appropriate. Consequently, the Commissioner had been unable to address the substance of Mr T's complaint about the Chief Constable. In that context, the Ombudsman found that it was not appropriate to insist on completion of the form, Mr T had provided sufficient information about the substance of the complaint to enable it to be taken forward, and there had been a failure to do so. The Commissioner agreed to terms of settlement that included the following:

- Work with Mr T to identify what reasonable adjustments might be made to ensure effective communication and provide him with a clear explanation of what (if any) reasonable adjustments would be made to facilitate communication.
- Ensure that all public-facing staff within the Commissioner's office received awareness training about how they deal with individuals with additional needs - including providing appropriate reasonable adjustments.
- Key learning points were to be shared with other staff and the relevant departments as appropriate.

Not upheld

As Ombudsman, I act impartially. Consequently, having scrutinised the evidence, there are many complaints that I do not uphold. Included in the selection below, is an example of an authority that had clearly addressed human rights considerations and was able to demonstrate to me that it had done so adequately.

201704517 [Housing - Anti Social Behaviour]

City and County of Swansea

Miss A complained that the Council had not adequately investigated her complaint of anti-social behaviour (ASB). Many of her concerns related to young children playing football, sometimes late into the evening, on Council owned land adjacent to her home. Miss A had asked the Council to stop the activity and to erect a 'no ball playing' sign on the property. A Council officer had said this would be unlikely to be agreed as it would be impossible to enforce such a warning. Whenever complaints were made, and officers visited the area to investigate Miss A's concerns, inevitably, the children had stopped playing ball games or had dispersed. Nevertheless, the Council had sent a letter to all residents in the area to ask that they remind their children to be mindful of other residents when out playing in the area.

Miss A complained, adding that the Council had not had due regard to its equality duties given she was disabled, and so it had also discriminated against her because children playing ball games had a more significant impact on her because of that disability. She felt that there were other areas the children could play in and that given her disability, they should not do so near her home. Miss A added that she felt her human rights had been breached.

The Ombudsman recognised that in Miss A's complaint, she had raised issues engaging Article 8 in relation to the enjoyment of her home, and also issues relating to the Equality Act. The Council told the Ombudsman that it had investigated Miss A's concerns and had considered her Article 8 rights. However, as this was a qualified right, it had also taken into account the children's rights, and the need for their play environment to be safe. The area around Miss A's home and the Council's land was such a safe environment. The Council added that the principles of the United Nations Convention on the Rights of the Child (UNCRC) were embedded in its policies and practices and so, in undertaking the balancing exercise afforded by Article 8, it had favoured the rights and needs of the whole community - especially the children and their right to play with friends in a safe environment. In asking residents who were parents to be mindful and respect other residents, it said that it had done all that it could.

The Ombudsman noted that the Council had demonstrated it had explicitly asked itself the relevant questions in considering Miss A's Article 8 rights and had weighed them up against the rights of children (as set out in the UNCRC). It was entitled to reach the conclusion it had and so was entitled to interfere with one person's rights to protect the rights and freedoms of others. This was expressly provided for by Article 8.

It was not for the Ombudsman to interfere with that decision which he concluded had been appropriately taken.

201706115 [Housing services – disabled grants]

Merthyr Tydfil County Borough Council

Ms Y complained that the Council had unreasonably denied her access to be considered for a Disabled Facilities Grant (DFG) through a delay in arranging an Occupational Therapist (OT) assessment, as required to progress the DFG.

The Ombudsman was satisfied that the wait Ms Y endured for her assessment was due to the high demand on the OT service, and so the Council's requirement to prioritise the needs of applicants. In this context, he was satisfied that there was no evidence to suggest that the Council failed to have regard for Ms Y's human rights. There were competing rights at issue.

201702158 [Planning - noise nuisance]

Denbighshire County Council

Mrs X complained about the Council's handling of her noise nuisance complaint relating to vibro-piling work being carried out on a new school development near to her home. Mrs X said that she suffered from headaches and buzzing in her ears because of the work complained about and that it exacerbated her medical condition and disability. The Council had investigated Mrs X's concerns having undertaken extensive monitoring. It had concluded that the work did not meet the threshold to be classed as a statutory noise nuisance. It added that no other resident in the vicinity had made complaints about the development work. Furthermore, it said that measures were put in place at the outset (as part of the planning consent process) to restrict the hours of activity and these were being adhered to. Therefore, it had done all it was reasonably required to do.

The Ombudsman was satisfied that there had been no maladministration on the part of the Council as it had investigated Mrs X's concerns correctly. He found that it was not within his remit to decide on a legal question as to what constituted a statutory nuisance. In considering the engagement of Mrs X's Article 8 rights (respect for her home and private life), the Ombudsman noted that it was a qualified right. In this case, he said it was relevant to note that the school was being constructed for the benefit of the wider community. In that context, it was reasonable in the balancing exercise to impact on the rights of an individual when the Council had taken all reasonable steps to limit the impact of the development work upon Mrs X.

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