COMMITTEE	**GOVERNANCE AND AUDIT COMMITTEE**
DATE	**21 MAY 2026**
TITLE	**OUTPUT OF THE INTERNAL AUDIT SECTION**
PURPOSE OF REPORT	**TO OUTLINE THE WORK OF INTERNAL AUDIT FOR THE PERIOD TO 31 MARCH 2026**
AUTHOR	**LUNED FÔN JONES – AUDIT MANAGER**
ACTION	**TO RECEIVE THE REPORT, COMMENT ON THE CONTENTS AND SUPPORT THE ACTIONS THAT HAVE ALREADY BEEN AGREED WITH THE RELEVANT SERVICES**

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1. INTRODUCTION

1.1 The Global Internal Audit Standards, Standard 11.3, Communicating Results state *"the chief audit executive must communicate the results of internal audit services to the board and senior management periodically and for each engagement as appropriate."*

1.2 Furthermore, Standard 15.1, Final Engagement Communication states *"the chief audit executive must disseminate the final communication to parties who can ensure that the results are given due consideration."*

1.3 The following report summarises the work of Internal Audit for the period from 26 January 2026 to 31 March 2026.

2. WORK COMPLETED DURING THE PERIOD

2.1 The following work was completed in the period from 26 January 2026 to 31 March 2026.:

Description	Number
Reports on Audits from the Operational Plan 2025-26	12

Further details regarding this work are found in the body of this report and in the enclosed appendices.

2.2 Audit Reports

2.2.1 The following table shows the audits completed in the period from 26 January 2026 to 31 March 2026, indicating the relevant assurance level and a reference to the relevant appendix.

TITLE	DEPARTMENT	SERVICE	ASSURANCE LEVEL	APPENDIX
School Transport Follow Up	Education	Schools	Satisfactory	Appendix 1
Breakfast Clubs Follow Up	Education	Schools	Limited	Appendix 2
School Transportation Follow Up	Environment	Transport and Countryside	Limited	Appendix 3
Building Regulations	Environment	Building Control Service	Satisfactory	Appendix 4
Information Management and Data Protection	Corporate	-	Limited	Appendix 5
Mandatory Training	Corporate Services	Learning and Organisational Development	Satisfactory	Appendix 6
Fire Arrangements	Corporate	-	Satisfactory	Appendix 7
Safeguards For Deprivation of Liberty	Adults, Health and Wellbeing	Safeguarding, Quality Control and Mental Health	Limited	Appendix 8
Fleet - Fuel	Highways, Engineering and YGC	Fleet	Limited	Appendix 9
Street Cleaning Overtime - Follow Up	Highways, Engineering and YGC	Street Cleaning	Satisfactory	Appendix 10
Category Management - Environment - Follow Up	Highways, Engineering and YGC	Category Management	Limited	Appendix 11
Bangor Crematorium	Highways, Engineering and YGC	Municipal Assets	Satisfactory	Appendix 12

2.2.2 The general assurance levels of audits fall into one of four categories as shown in the table below.

LEVEL OF ASSURANCE	**HIGH**	Certainty of propriety can be stated as internal controls can be relied upon to achieve objectives.
	SATISFACTORY	Controls are in place to achieve their objectives but there are aspects of the arrangements that need tightening to further mitigate the risks.
	LIMITED	Although controls are in place, compliance with the controls needs to be improved and / or introduces new controls to reduce the risks to which the service is exposed.
	NO ASSURANCE	Controls in place are considered to be inadequate, with objectives failing to be achieved.

3. WORK IN PROGRESS

3.1 The following work was in progress as at 31 March 2026:

- Education Outside Schools *(Education)*
- Field Workers' Awareness of the Protection Policy *(Corporate)*
- Out-of-County Payments *(Children and Family Support)*
- Emergency Accommodation Costs *(Housing and Property)*

4. RECOMMENDATION

4.1 The Committee is requested to accept this report on the work of the Internal Audit Section in the period from 26 January 2026 to 31 March 2026, comment on the contents in accordance with members' wishes, and support the actions agreed with the relevant service managers.

Appendix 1

SCHOOL TRANSPORT FOLLOW UP

1. Background

1.1 An Internal Audit of School Transport was undertaken as part of the 2024/25 plan, to ensure that suitable arrangements were in place for the administration and provision of a free school transport service for qualified children in accordance with the Education Act 1996, as well as income collection arrangements for ineligible children. A limited level of assurance was given to the audit, that is to say, although controls were in place, compliance with the controls needed to be improved and/or new controls introduced to reduce the risks to which the service is exposed.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to ensure that the agreed actions resulting from the latest full audit were implemented in a timely manner to mitigate the risks identified. To accomplish this, the audit covered the verification of records and supporting documentation.

3. Audit Level of Assurance

3.1 The controls for risk mitigation were examined. The auditor's assessment concludes that the level of assurance of the audit is as follows:

Assurance Level	Description
SATISFACTORY	**There are controls in place to achieve objectives but there are aspects of the arrangements that need tightening to further mitigate the risks.**

4. Current Score Risk

4.1 The audit's risks are as follows:

Risk Level	Number
VERY HIGH	0
HIGH	0
MEDIUM	1
LOW	0

5. Main Findings

5.1 Of the 5 operations agreed from the original audit, 4 were found to have been implemented, the conclusions are reported below. As a result, a revised agreed action plan is presented attached to this report.

5.2 The Transport Co-ordinator confirmed that the Transport Team are still not notified when there is a significant change in a child's circumstances, i.e. a change that would affect their right to receive free transport. While the schools report similar changes in the SIMS system, which are then fed into the Synergy system (to which the Transportation Team has access), without the change being highlighted, thousands of records would have to be checked to identify changes. The Systems Support Officer explained that SIMS is in the process of being replaced by a new system, Bromcom, which will allow better monitoring of the data. In the meantime, he noted that it is possible to run reports from Synergy of any significant changes to share with the Transportation Team. By the time the draft report was released, it was confirmed that arrangements had been put in place where the Transport Team receive a monthly report, automatically generated from the Synergy system, highlighting any children who had changed schools. It was reported that the report had enabled the Transport Team to identify two children already where their journeys needed to be changed.

5.3 For the period 01/04/25-02/02/26 it was found that 3,371 post-16 travel tickets were provided. From the sample of 20 reviewed in detail, it was found that the applicants all live in Gwynedd, and at least 3 miles away from school or college, making them eligible for the ticket. The Education Transport Manager confirmed that consideration had been given to reintroducing a fee for post-16 travel tickets, but that the Council did not favour the idea.

5.4 It was found that the Transport Team is now preparing reports to the School Group Accountant every term, stating the number of new bus passes issued, i.e. following the loss of a bus pass. For the period September-December 2025, 26 tickets had been provided, with only £10 of income recorded in the ledger. Passes are £5 each. It is assumed that the schools do not collect the income, or that it is incorrectly referenced. No response had been received from the Group Accountant by the time the draft report was released.

6. Actions

The relevant officers are committed to implementing the following actions to mitigate the risks highlighted:

- **Once operational, carry out checks and synchronise data to ensure that the information on the 'Synergy' and 'Bromcom' systems is accurate and up to date, arranging for any deficiencies to be corrected promptly.**

Appendix 2

BREAKFAST CLUBS FOLLOW UP

1. Background

1.1 An Internal Audit of Breakfast Clubs was carried out as part of the 2024/25 plan, to ensure that appropriate arrangements are in place for the holding of breakfast clubs, as well as the administration of income from the care element during the sessions.

2. Purpose and Scope of the Audit

2.1 The purpose of the audit was to ensure that the agreed actions resulting from the latest full audit were implemented in a timely manner to mitigate the risks identified. To achieve this, the audit covered the verification of records and supporting documentation, as well as conduct site visits.

3. Audit Assurance Level

3.1 The controls for risk mitigation were examined. The auditor's assessment concludes that the level of assurance of the audit is as follows:

Assurance Level	Description
LIMITED	**While controls are in place, compliance with the controls needs to be improved and/or new controls introduced to reduce the risks to which the service is exposed.**

4. Current Risk Score

4.1 The audit's risks are as follows:

Risk Level	Number
VERY HIGH	0
HIGH	2
MEDIUM	4
LOW	0

5. Main Findings

5.1 Of the 10 actions agreed from the original audit, 6 were found to have been implemented, the conclusions are reported below. As a result, a revised agreed action plan was presented.

5.2 As in the full audit, the breakfast clubs of Waunfawr, Gwaun Gyfni, and Dolbadarn schools were visited to carry out the follow up. For the 3 schools, records relating to children with allergies ranged from document to document, i.e. kitchen records disagreeing with those of the Catering Team, making it difficult to identify all children with allergies. Not only did the names disagree, but also the type of foods the child had an allergy to.

On one occasion, it was found that the school had provided documentation in relation to a pupil with an allergy, but that the kitchen had not acted as there was no supporting medical evidence. In addition, it was found that 2 of the 3 schools did not display pictures of children with allergies on the kitchen wall, as stated in the Allergy Policy. In discussion with the Education Catering and Cleaning Service Manager, it was discovered that the previous Manager had been instructed by the Data Protection Team not to display pictures of the children, but that the policy had not been updated to reflect that. It was acknowledged that the policy was complex, and some of the content was now irrelevant. It was confirmed that meetings had been held with the Welsh Local Government Association, as well as enquiries to neighbouring authorities to formulate a new, simpler policy, which would place more emphasis on the receipt of supporting medical evidence.

5.3 Although the Allergy risk assessments seen in the Allergy Folders during the visits were not up to date, copies, reviewed in the last year, were received by the Education Catering and Cleaning Services Manager. It was noted that each school's folders would be updated with the current assessments as soon as possible.

5.4 It is expected that separate equipment is available for the provision of food to children with allergies, i.e. a purple plate, bowl, and cup. Although the full audit revealed that the kitchen at Ysgol Dolbadarn did not have purple bowls, it was found that this was still the case during the most recent visit. It was confirmed that the School Catering and Cleaning Team Leader had ordered bowls prior to the release of the draft report. It is noted that consideration has been given to the provision of separate eating utensils for children with allergies, but that the Public Protection service has confirmed that sterilisation alone is adequate.

5.5 As for the content of the breakfast, foods ordered must be as set by the Government. There are four categories, and one option must be provided from each category. The categories are: Milk or yogurt-based beverages, Cereals, Fruit and Vegetables, and Bread. At the time of the full audit, juice was being provided as the fruit option. Since then, the juice has been replaced, offering a drink of water or milk in its place. In Waunfawr school a bowl of fruit was spotted at the entrance to the kitchen, with several children asking for fruit during the session. In Gwaun Gyfni and Dolbadarn schools, although the staff noted that fruit was available to any child who requested any, it was found that the fruit bowls were hidden out of the children's view, and that the quality of the fruit was also poor. The Education Catering and Cleaning Service Manager noted that they had struggled with suppliers recently, where orders were not being fully received, and the quality of the food was poor.

5.6 Despite being involved in fire drills in the schools since the full audit, it was found that kitchen staff remained without access to the Council's E-learning portal to complete mandatory modules.

6. Actions

The relevant officers are committed to implementing the following actions to mitigate the risks highlighted:

- **Continue to draw up a new, simpler Allergy Policy, arranging training for all relevant staff on the new content.**
- **Consider using the Bromcom system to keep electronic records, to enable easier updating.**
- **Arrange a meeting with headteachers to re-introduce the content of the new Allergy Policy, emphasising the need to provide information in relation to allergies accurately, and promptly to the Catering Team.**
- **Ensure that each kitchen's Allergy folders are up to date with current risk assessments.**
- **Identify any schools that do not have the appropriate equipment, ensuring that an order is arranged immediately.**
- **Kitchen staff are reminded that fruit needs to be highlighted and offered during all breakfast club sessions, monitoring for future orders.**
- **Arrange for an electronic device to be available in each kitchen to enable staff to log in to the E-learning Portal.**

Appendix 3

SCHOOL TRANSPORTATION FOLLOW UP

1. Background

1.1 An Internal Audit of School Transport Project Management was carried out as part of the 2024/25 plan, to ensure that appropriate arrangements are in place for managing and monitoring contracts with school transport providers and that robust safeguarding controls are in place to protect pupils. As part of the original audit, contracts for a sample of suppliers were checked to ensure they were complete and met service requirements under the Education Act 1996; the tendering process for companies was reviewed; contract monitoring and management arrangements were examined and ensure that DBS checks are carried out in a timely manner and that suppliers comply with relevant Council policies, including the Alcohol and Drugs Policy.

2. Purpose and Scope of Audit

2.1 The purpose of the audit is to ensure that the agreed actions arising from the most recent full audit have been implemented in a timely manner to mitigate risks. To achieve this, the audit included reviewing records or supporting documentation.

3. Audit Level of Assurance

3.1 The controls for risk mitigation were examined. The auditor's assessment concludes that the level of assurance of the audit is as follows:

Assurance Level	Description
LIMITED	**While controls are in place, compliance with the controls needs to be improved and/or new controls introduced to reduce the risks to which the service is exposed.**

4. Current Score Risk

4.1 The audit's risks are as follows:

Risk Level	Number
VERY HIGH	0
HIGH	1
MEDIUM	1
LOW	0

5. Main Findings

5.1 Five actions were agreed as part of the original audit in December 2024, three with a risk score of 15, one with a risk score of 12, and one with a risk score of 6. It was found that the actions had been partially implemented, and the findings are reported below; however, ongoing work is in place to safeguard pupils using school transport.

5.2 The original internal audit identified that one of the risks to be mitigated was the failure to properly monitor and manage school transport contracts, including testing against the Council's Alcohol and Drugs Policy. Evidence was seen that the Transport team had contacted operators to check whether alcohol and drugs testing is carried out, but from the sample of responses received there is no assurance that testing is taking place by all suppliers. In addition, the Transport Manager confirmed that if an allegation were received regarding a driver being under the influence of alcohol or drugs, they would contact the Police and carry out visits and testing through engagement with Corporate Services; however, such incidents are very rare.

5.3 At the time the original audit was carried out, 5 out of 12 suppliers in the sample did not have an internal risk assessment available, despite it being a requirement for suppliers to provide their own risk assessment when entering a contract with the Council. The same sample was reviewed for a second time, and 2 out of 12 risk assessments were still not available. These two suppliers were no longer operating school contracts and therefore were not required to provide a risk assessment.

5.4 At the time of the original audit, the Department was unable to regularly monitor compliance with contracts due to a lack of resources, and therefore checks were carried out only in response to complaints received. No clear supporting evidence of these checks was available during the audit. The Transport Manager confirmed that a new arrangement is in place with the Licensing service to visit schools to conduct termly checks. A copy of the monitoring spreadsheet was received and it was noted that some monitoring work had been carried out during September, October and November 2025; however, there were gaps in the spreadsheet and no detailed evidence was seen to support these entries.

5.5 One of the actions from the original audit was to move to the Council's DBS system to retain up-to-date DBS details and conduct checks. The service has now moved from using paper forms to using the Council's DBS system. However, the service still maintains an Excel spreadsheet of DBS details, with the IT service currently investigating ways to streamline this. Bus drivers are issued with an identification card following the DBS checking process. The Transport team confirmed that, as part of joint working with the Education department, there is an intention to raise general awareness among stakeholders (school staff, parents/guardians, etc.) that those providing education transport services on behalf of the Council must hold and wear an identification card. If there are any concerns, these should be reported to the Integrated Transport Unit so that an investigation can be carried out.

5.6 At the time of the audit, the Education Transport Policy was not up to date on the Council's website. A revised policy was presented to Cabinet in January 2026 to seek approval to undertake a consultation in February or March 2026. The results of the consultation will be reported to the Education and Economy Scrutiny Committee in June 2026. By October 2026, the revised Education Transport Policy is expected to be published and to be operational by September 2027.

6. Actions

The Service has committed to implementing the following actions to mitigate the risks identified:

- **Contact operators periodically to check whether alcohol and drugs testing is being carried out.**
- **Use the action points system to penalise companies that fail to submit documentation.**
- **Continue to regularly monitor and manage school transport contracts and ensure that thorough records are maintained.**
- **Ensure that the Education Transport Policy is published on the Council's website once approved and review the links on the Corporate website to ensure that the current version of the policy is included.**

Appendix 4

BUILDING REGULATIONS

1. Background

1.1 The main purpose of Building Regulations is to ensure reasonable standards of health and safety for persons in or around buildings, energy conservation, and access and facilities for people with disabilities.

1.2 Building Regulation approval will be required for most building work, including erection of a new building, re-erection of an existing building, extension or alteration of a building, installing windows, structural alterations, heat-producing equipment, modifications to a building's drainage system, underpinning foundations, installing and alterations to most electrical circuits within dwellings, and alterations and refurbishments of certain 'thermal elements'.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to ensure that the service had robust arrangements in place to comply with statutory requirements. To achieve this, the original audit included reviewing staff training, auditing a sample of applications to ensure compliance with standards, assess the decision-making process, and verifying the accuracy of the fees charged.

2.2 However, reliance was placed on the findings of a similar internal audit by the Local Authority Building Control (LABC) professional body conducted in April 2025 as part of the ISO 9001 requirement, to avoid repeating audit tests.

3. Audit Level of Assurance

3.1 The controls for risk mitigation were examined. The auditor's assessment concludes that the level of assurance of the audit is as follows:

Assurance Level	Description
SATISFACTORY	**There are controls in place to achieve objectives but there are aspects of the arrangements that need tightening to further mitigate the risks.**

4. Current Score Risk

4.1 The audit's risks are as follows:

Risk Level	Number
VERY HIGH	0
HIGH	0
MEDIUM	1
LOW	0

5. Main Findings

5.1 The Building Control service was subject to an internal audit from the LABC in April 2025 as part of the ISO 9001 requirement. A copy of the report was received, covering a wide range of areas, including compliance with regulatory requirements, risk management, system operations, record keeping and management, complaint handling, staff competence, site inspections, key performance indicators, assessment of the decision-making process, and a verification of a sample of applications, completion certificates, and initial notifications.

5.2 Since the tests carried out by LABC closely matched the scope of the internal audit, and was conducted by experienced professionals, it was decided not to repeat these tests and to focus on the findings and conclusions of the LABC report, which includes recommendations and opportunities for improvement. The report was found to be positive, but three opportunities for improvement were identified along with three compliance deficiencies, as well as specific remedial actions to mitigate these risks to be completed by July 2025.

5.3 The improvements identified included the need to review and adopt the Risk Treatment Plan, as well as to share it with relevant staff to ensure full awareness and compliance across the service. It was also recommended that the service provide specific Building Control induction for new staff, so that consistent arrangements are in place for developing competence. In addition, the approach to inspection planning should be reviewed to determine whether a more specific, risk-based approach is needed as there is no formal notification process for communicating the plan with the client.

5.4 The report noted three cases of non-conformance, namely: the lack of a formal process for conducting annual performance evaluations, as required by LABC; the lack of a structured procedure for recording and managing conflicts of interest; and the absence of a standard proforma for plan checks, which is essential to ensure consistency and completeness in the process.

5.5 The Building Control Service Manager was asked about the status of the corrective or preventative actions and it was confirmed that they have been partially implemented. Appropriate evidence was received for the three cases of non-compliance and one opportunity for improvement. An information package for clients has been created and is sent out to clients when applications are registered. It notifies the customer when they need to contact the service and provides information about the process. A conflict-of-interest log document has been created in February 2026, but has not yet been completed by staff, as additional discussions and training are required. A proforma plan check document has also been created for all staff to complete and save on file when reviewing plans, but further training and discussion is also required before it is adopted in practice. The service has also begun conducting annual staff appraisal as part of the annual performance evaluations.

5.6 Two of the improvements are still outstanding and require attention. The Risk Treatment Plan had not been reviewed and adopted, and the service had not provided induction training to new staff. It was noted that a lack of administrative resources is the main reason for the lack of progress, but it was explained that the service will work on these items with the intention of completing them before the end of the year.

5.7 Despite not fully implementing all the changes, the LABC was of the general view that the Building Control Service operates effectively, with strong technical expertise, robust engagement with contractors, and continuous improvements to processes. As a result, it was decided to revisit Building Control during the 2026/27 financial year to conduct a further audit.

6. Actions

The Service has committed to implementing the following steps to mitigate the risks highlighted.

- **Act on the two opportunities for improvement identified in the LABC report, which include –**
  - **Reviewing and adopting a Risk Treatment Plan and sharing it with relevant staff.**
  - **Providing specific induction training on Building Control to new staff.**

Appendix 5

INFORMATION MANAGEMENT AND DATA PROTECTION

1. Background

1.1 Article 4 of the UK General Data Protection Regulation (GDPR) defines data processing as any operation performed on personal data. The processing of personal data must be lawful and to ensure that data is processed lawfully, the Council needs to confirm that they are able to identify and demonstrate the legal basis for each action, establish processes and policies and ensure compliance and maintain operating records of processes 'with full detail'. Where the Council processes data through a third party an agreement is required to be in place to ensure that both parties as the 'data controller' and 'data processor' comply with the legal GDPR requirements.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to ensure that suitable arrangements were in place to manage information and protect personal data collected and shared with third parties to ensure lawful processing of the data. To achieve this, the audit encompassed a review of the Council's policies and procedures for processing and sharing personal data and ensuring compliance with the UK's Data Protection Regulations.

3. Audit Level of Assurance

3.1 The controls for risk mitigation were examined. The auditor's assessment concludes that the level of assurance of the audit is as follows:

Assurance Level	Description
LIMITED	**Although controls are in place, compliance with the controls needs to be improved and / or introduce new controls to reduce the risks to which the service is exposed.**

4. Current Score Risk

4.1 The audit's risks are as follows:

Risk Level	Number
VERY HIGH	0
HIGH	1
MEDIUM	3
LOW	0

5. Main Findings

5.1 The policy and procedure was obtained and it was seen that the General Data Protection Regulation (GDPR) policy and training was mandatory. In addition, it was confirmed that Data Protection face to face refresher courses are scheduled for 2026, including decisions on data sharing and when it is appropriate to do so.

5.2 A list of the Council's system owners was received by the Senior Statutory Information Protection Officer. The register was found to have been established in 2023 and has since been updated. A sample of the main systems was selected across the Council to confirm completeness and its relevance. In addition, the Procurement Service provided a list from the ledger of the highest paid suppliers to possibly identify whether data processing processes and contracts existed beyond the list of system owners. The Council has a WASPI agreement ('Wales Accord on the Sharing of Personal Information') and shares information under the multi-agency data sharing protocol with other authorities involved within health, education, protection, crime prevention and social welfare that allow for the secure sharing of data in compliance with the UK GDPR.

5.3 From the register of system owners received by the Senior Statutory Information Protection Officer, out of 30 systems checked, a response was received in respect of 28 systems. Of the 28, 4 of the systems were found to no longer exist. These appear to be a mix of data processors and license agreements with third parties, and 2 of the systems have been reported to expire within the next financial year (WCCIS & Cyborg).

5.4 As a result, a query was raised with the IT Service on whether there is a centralised list of systems to support the list received by the Senior Statutory Information Protection Officer to identify internal systems, reviewing renewal dates for contracts and exceptions that may suggest data processing activities with a third party. However, no list exists, including a plan for prioritising systems for data recovery in an emergency.

5.5 The Council has a data processing agreement template for contractors to sign which sets out the Council's terms for how they want Contractors, as the data processor to handle their data. From the sample of systems selected for review, 17 systems appear to be processing data, and the rest with a license agreement and/or support system agreement in place. While 17 appear to be processing data, a formal agreement was received for only 8 with the remaining (9) having provided the companies' privacy statement. Out of the data processing agreements only 3 had used the Council template and the rest had used the processor's agreement. The agreements were obtained to check for sufficiency and compliance with article 28 of the UK GDPR.

5.6 For 7 of the systems that had a licence and or support agreements, the Senior Statutory Information Protection Officer expressed that all systems including internal ones with external support should have a data processing agreement in place.

5.7 In addition to this, the agreements were checked in order to verify responsibilities regarding cyber security and assurance in terms of supply chain attacks. According to the regulations, article 32, although the data is processed by an external company, the Council is responsible for the data and therefore the processor is required to take measures to protect data against cyber-security attacks. It was found that not all agreements included conditions for protecting against cyber security attacks.

5.8 As part of the audit, checks were undertaken on compliance with article 35 of the UK GDPR by enquiring about the data protection impact assessment (DPIA) for new projects/processes established. It was found that not all selected projects required an impact assessment, this is dependent on the risk and the type of data being processed. Of those that appear to be processing personal data, 5 DPIA were confirmed to be available out of 15 possible systems.

5.9 Supplier procurement arrangements were checked to ensure that appropriate due diligence checks are in a place, in acting as the data controller. The current procurement arrangements ensure that there are certain conditions and questions that suppliers must meet when submitting a tender but ultimately the procurer is responsible for conducting the checks. No evidence was received that checks had been carried out/kept.

5.10 In addition, from the sample of agreements received, it was checked whether there was an audit/performance measurement clause in a place, where the Council can obtain assurance that the processor has implemented the appropriate measures or complied with the terms of the contract, or both. Most of these were found to contain conditions but no confirmation that they are implemented which means that no guarantees can be obtained that contracts comply with articles 28, 32, and 5(2) of the UK GDPR.

6. Actions

The Information Service is committed to co-ordinating/implementing the following actions to mitigate the risks highlighted:

- **Provide specialist training to raise awareness of DPIA and data processing agreements including the need to use the Council's data processing template, where applicable.**
- **Information Management Team with IT to coordinate with other services to identify a single central register of data processing activities.**
- **Review the conditional procurement questions to ensure they are sufficient for the protection of the Council's data.**
- **Issue instructions to departments to take ownership of their data by providing them with access to the information so that they can update any changes to the central list as needed.**
- **Consider conducting a sample of checks to the list on a regular basis to confirm its relevance.**

Appendix 6

MANDATORY TRAINING

1. Background

1.1 The Council currently has 8 mandatory training titles (Data Protection, Safeguarding, Equality, Language Awareness, Violence Against Women, Domestic Abuse and Sexual Violence, Prevention, Health and Safety and Freedom of Information) which are expected to be completed by all members of staff.

1.2 Training can be completed by completing an e-module. In exceptions, depending on the requirements of the training they can also be completed face-to-face. The e-modules are available on the e-learning Portal and all officers have access to the modules via salary number as the user identification details.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to ensure that suitable arrangements were in place to ensure that officers complete mandatory training. To achieve this, the audit covered the reviewing the completion statistics for mandatory training, the availability of mandatory training and the Council's plans for ensuring that mandatory training is completed by Council officers in a timely manner.

3. Audit Level of Assurance

3.1 The controls for risk mitigation were examined. The auditor's assessment concludes that the level of assurance of the audit is as follows:

Assurance Level	Description
SATISFACTORY	**There are controls in place to achieve objectives but there are aspects of the arrangements that need tightening to further mitigate the risks.**

4. Current Score Risk

4.1 The audit's risks are as follows:

Risk Level	Number
VERY HIGH	0
HIGH	0
MEDIUM	7
LOW	0

5. Main Findings

5.1 Mandatory training is found available in the form of e-modules, but some training sessions are available through MoDS (Self-Service), which includes face-to-face sessions or more comprehensive e-modules.

5.2 The E-learning Officer expressed that the Learning and Development Service is supporting departments by creating a report of completion statistics for Safeguarding training to report to the Safeguarding Executive Group. The Designated Safeguarding Officers within the Safeguarding Executive Group are responsible for cascading the lists of individuals who have not completed the three mandatory modules under the Safeguarding umbrella which are Prevention, Safeguarding, and Violence Against Women so that they are completed.

5.3 In addition, a dedicated officer was appointed in November 2025 to support the services by visiting frontline sites to assist staff in completing the Safeguarding training.

5.4 The E-learning Officer monitors completion statistics for training via the Power BI dashboard. It shows clear data for each Mandatory Title, including numbers and percentages for the Council as a whole and for each individual Department. It is also possible to create a list of individuals who have not completed the training, broken down by Department or Service. This data is available to Heads of Services and Managers on request on an ad hoc basis, or access can be created for them to the dashboard. The Safeguarding and Domestic Abuse mandatory training statistics are now being presented at the performance challenge meetings and there are plans to extend this for all mandatory training in the future.

5.5 The Council recognises that there is a shortage in the numbers of frontline officers completing mandatory training, with the likelihood that the numbers are low due to a lack of access to a computer during working hours. Although salary numbers are used to access the training modules, it has been reported that many remain without an email address to allow for the training to be recorded, which may mean that the records/statistics being kept are not complete/up-to-date. In response, the Digital Sub-Group under the Gwynedd Digital Scheme is working on extending the provision of digital equipment, particularly to frontline staff.

5.6 The Learning and Development Hub on the intranet contains information on mandatory training and the Learning and Development manual states 'The requirement to complete the Mandatory titles is part of the working contract of each of us as members of staff of Cyngor Gwyneddl. You can check if you have completed a Mandatory Title by going to My Employment Learning Program in the Self Service. The entry will be updated weekly. Completion record reports will be generated to various services as required. In addition, Managers can view their Staff's record on the 'Self Service'. Clear instructions setting out responsibilities and accountability for monitoring mandatory training were not in place. In addition, not all officers have access to a computer to check their Learning and Development Program.

5.7 Due to a lack of tools and ways to communicate with frontline staff, reliance is placed on managers to act and direct staff to mandatory training in accordance with the guidance Support for Frontline Workers, Mandatory Titles. Of the sample of staff checked from the Gwynedd Jobs System, 33% appear to have not completed mandatory training and those staff are in posts with no computer/frontline posts.

5.8 A sample of 50 staff training records were checked and it was found that 13/50 had no training record against their names and these appeared to be frontline workers or duties without access requirements to a computer such as kitchen assistants, carers and cleaners. 22 had not completed mandatory training with over 80% of these being frontline workers. The remainder, 15 who had completed it were a mix of office and frontline workers and likely with access to a computer in their job role.

5.9 It appears that an introduction to the mandatory learning and training programme is part of the introduction of new staff and in the welcome period pack for new staff. However, the Learning and Development Service reported that new staff introduction arrangements are inconsistent across the Council and therefore they are unsure if all new staff are receiving a full introduction and are aware of the need to complete the mandatory training as part of their probationary period, with some officers well into their careers before completing mandatory title training.

5.10 Learning and Development has three operational systems for recording training for staff. The E-learning Portal includes the training e-modules for staff while the Policy Centre is a separate system with a record of all Council policies. The E-learning Officer expressed that the data from these systems are uploaded to the MoDS Self-Service system on a weekly basis which generates the monitoring statistics. Because the Council's training and policies operate on different systems, it can cause confusion for staff to keep track of their progress and identify training that has not been completed.

5.11 It was asked whether the systems sends reminders for targeting officers who need to complete training, read a new policy or renew training and the response received was that the system acquired is basic and therefore the reminders are not part of the current package unless there is a decision to upgrade the package which will be an additional cost to the Council. However, with the Welsh Government providing statutory guidance on safeguarding training through the Safeguarding Training, Learning and Development Standards and Safeguarding Procedures Wales, which are based on the Social Services and Well-being (Wales) Act 2014, there is a requirement for Safeguarding training to be renewed to "Group A" every 3 years. This means that there will be a need for ways to identify training renewal dates as well as to remind staff of the date the training ends. The Talent and Apprenticeships Leader reported that they are considering upgrading the system and that there is a bid for more monies to upgrade the existing system. According to the Learning and Development Manager there will be a better understanding of what options are available once we understand the extent of the new i-Trent system.

5.12 It was questioned whether the list of mandatory training titles was now outdated and that recent training such as Cyber Security and Fraud Detection that meets the Council's principles needs to be included. It has been reported that the Council has a Learning and Development Panel which meets 2 times a year. The Talent and Apprenticeships Leader explained that there are tiers for deciding on mandatory titles. Mandatory titles usually support what the council needs to complete to meet legal duties, followed by core training followed by training for on-the-job development. The decision to include Freedom of Information as mandatory training was made at the last meeting in June 2025.

6. <u>Actions</u>

The Learning and Development has committed to implementing the following steps to mitigate the risks highlighted.

- **Introduce formal and clear instructions for identifying those responsible for monitoring completion of mandatory training and reporting to the heads of services so that the message can be cascaded through management lines.**
- **Consider upgrading the current system so that mandatory training that needs to be renewed can be identified and staff reminded to complete training that has not been completed/renewed.**
- **Discuss with Learning and Development staff from councils that use the iTrent system in order to understand the options available to address some of the issues identified in this report, for example the ability to issue reminders to staff to ensure updates are made in a timely manner.**
- **Include Mandatory Training completion statistics as part of Performance Challenge meeting's measurements.**
- **Consider regularly monitoring mandatory training completion statistics and reporting to Heads of Service where completion rates are low.**
- **Act on the requirement for officers to complete refresher courses every 3 years.**
- **Consider the possibility of requiring new staff to complete mandatory training at the start of their posts.**
- **Review induction arrangements by obtaining feedback from the various departments and put arrangements in place to try to achieve greater consistency in the induction of new staff across the Council.**

Appendix 7

FIRE ARRANGEMENTS

1. Background

1.1 The Council owns several properties, including offices, schools, libraries and various other buildings, and it must ensure that workers and visitors are protected from fire. To this endeavour, the Council must follow the Regulatory Reform (Fire Safety) Order 2005 (amended 2023), which places a responsibility on the Council to ensure that appropriate fire safety measures are in place in its properties, including carrying out fire risk assessments, implementing suitable preventative and protective measures, and provide information, instructions and training

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to ensure that the Council's fire management arrangements were appropriate. To achieve this, the audit involved reviewing the arrangements of the Safety and Compliance Team for visiting, inspecting, and reporting on fire arrangements for a sample of properties.

3. Audit Level of Assurance

3.1 The controls for risk mitigation were examined. The auditor's assessment concludes that the level of assurance of the audit is as follows:

Assurance Level	Description
SATISFACTORY	**Controls are in place to achieve their objectives but there are aspects of the arrangements that need tightening to further mitigate the risks.**

4. Current Risk Score

4.1 The audit's risks are as follows:

Risk Level	Number
VERY HIGH	0
HIGH	0
MEDIUM	3
LOW	0

5. Main Findings

5.1 The impact of inadequate fire management arrangements can be serious, and for this reason it is essential that the Council follows the Corporate Fire Safety Policy by recognising its responsibilities as an employer, and it is committed to ensuring, as far as is reasonably practicable, the safety of its workers, as well as the safety of any other person who may be affected by fire hazards. Fire risks have been included on the corporate risk register.

5.2 Site managers have been appointed for each property, and they are responsible for creating and maintaining a safe day-to-day working environment at the site. The Housing and Property Department's Safety and Compliance Team visit the properties annually to carry out checks, identify deficiencies, arrange repair work, and offer support to the site manager. The Safety and Compliance Team follows the Regulatory Reform (Fire Safety) Order 2005 (amended 2023), which means that a thorough fire risk assessment must be carried out for each property whenever there is a change in use or site manager, followed by annual inspections.

5.3 A sample of 6 properties was selected from the Council's insurance database. The sample included offices of various sizes, a Youth Centre, a Library, and a Secondary School. Inspection records of the Safety and Compliance Team were reviewed for these properties, encompassing a wide range of fire management and prevention arrangements, as well as other matters such as legionella and asbestos.

5.4 One property was excluded from the sample as it is used and managed by an external organisation. At the time of the audit, no inspection report was available for one property because the visit took place in April 2025 and the staff member had since left before completing the report. Reports are expected to be submitted within six weeks of the visit. For three other properties, it was found that thorough inspections had been carried out and that findings and recommendations had been made. Some of the recommendations included receiving and recording fire training, arranging Portable Appliance Testing for electrical equipment, removing obstructions from evacuation points, and placing fire procedure notices in appropriate locations. Some Internal Audit Service visits of external establishments such as care homes also include fire management elements, and findings have included failures to carry out and record equipment tests as frequently as expected. The Corporate Health & Safety Team also visit properties to review the contents of their blue boxes, namely the property's fire test records, fire plan etc

5.5 It was found that Site Managers had been designated for each property in the sample. A Site Management training course is available which provides the necessary knowledge and skills for managers to deal with health and safety matters relating to fire, among other topics. Although all site managers in the sample had attended the course (except one who had recently been appointed), training records in MODS suggest that a considerable amount of time can pass before attending the course after being appointed to the role. Refresher courses are available to remind managers of the arrangements, and if the managers have not completed the refresher course within 3 years, they must retake the original course.

5.6 A Fire Awareness e-module is available on the e-Learning Portal, but it was noted that several site managers had not completed it, nor had they read the Corporate Fire Safety Policy. Completing the module and accepting the policy is something every member of staff should do, but it is recognised that the Site Management course surpasses the e-learning module.

5.7 It is the Site Manager's responsibility to act on the Safety and Compliance Team's recommendations, but progress is not followed up until the next annual visit. However, some of the actions are the responsibility of the Housing and Property department, and the department says that they prioritise these actions based on risk.

5.8 Departmental Health and Safety forums are a good opportunity to discuss fire related matters, and the Finance Department has already discussed and circulated an email encouraging staff to read and complete the Fire Awareness e-learning module, as well as committing to discuss PAT testing, which, according to the Council's Portable Electrical Appliance Testing Procedure, is the responsibility of the department, although this does not appear to be widely known.

5.9 For the final property in the sample, the Pencadlys offices, the most recent inspection records, September 2023, were received. No inspection has been carried out since then due to ongoing work, such as office moves and the redevelopment of the former reception area. Normally, this would require several thorough fire risk assessments for each change, but the Safety and Compliance Team has decided to work collaboratively with the offices team while the work continues, and the fire risk assessment is intended to be carried out soon. However, the Corporate Health & Safety Team is of the opinion that periodic assessments should have taken place.

5.10 Following a meeting of the Corporate Forum, weaknesses in the arrangements for evacuating the main offices in a fire emergency were highlighted. The risk is included on the corporate risk register and is one of the weaknesses highlighted in the 2023 audit. This stems from the fact that offices of this size require fire marshals to be responsible for identifying who is present on the day, but hybrid working is undermining the effectiveness of the current arrangements..

6. <u>Actions</u>

The service has committed to implementing the following steps to mitigate the risks highlighted.

- **New Site Managers to attend a Site Management course as soon as possible, together with ensuring that they attend refresher courses within 3 years.**
- **Health and Safety Forums to try and encourage everyone, especially Site Managers to complete the Fire Awareness e-module and read the Corporate Fire Safety Policy.**
- **Departmental Health and Safety Forums to remind departments to arrange PAT tests.**
- **Complete reports within 6 weeks of the visit.**
- **Escalate serious weaknesses, or those which are regularly highlighted to the Site Manager's Line Manager.**
- **Carry out a fire risk assessment on the Council's Headquarters.**

Appendix 8

SAFEGUARDS FOR DEPRIVATION OF LIBERTY

1. Background

1.1 Deprivation of Liberty Protection Arrangements (DoLS) provides a legal framework under the Mental Capacity Act 2005 to protect individuals who lack capabilities and are deprived of liberty. These safeguards were introduced in 2009 and expanded following the Cheshire West ruling in March 2014 and aim to ensure that such arrangements are lawful and in the best interests of the individual.

1.2 The Liberty Protection Safeguards (LPS) were introduced in the Mental Capacity (Amendment) Act 2019 and will replace the Deprivation of Liberty Safeguards (DoLS). The Welsh Government consulted on draft Regulations for Wales to gather stakeholder views on the proposed approach to be adopted for the LPS while the UK Government consulted on draft Regulations for England. The UK Government has also consulted on a draft Code of Practice which will apply to England and Wales.

2. Purpose and Scope of the Audit

2.1 The purpose of the audit was to ensure that suitable planning and preparation arrangements were in place to respond to the new requirements of the Liberty Protection Safeguards (LPS) which will replace the Deprivation of Liberty Safeguards (DoLS), as well as checking if there are appropriate arrangements in place for operating on the current DoLS referrals. To achieve this, the audit covered ensuring that adequate arrangements were in place for the new regime and review a sample of DoLS referrals to provide an assurance on arrangements.

3. Audit Assurance Level

3.1 The controls for risk mitigation were examined. The auditor's assessment concludes that the level of assurance of the audit is as follows:

Assurance Level	Description
LIMITED	**While controls are in place, compliance with the controls needs to be improved and/or new controls introduced to reduce the risks to which the service is exposed.**

4. Current Risk Score

4.1 The audit's risks are as follows:

Risk Level	Number
VERY HIGH	0
HIGH	1
MEDIUM	2
LOW	0

5. Main Findings

5.1 The last audit was carried out in 2022 and reported that 'Although controls are in place, compliance with the controls needs to be improved and / or introduce new controls to reduce the risks to which the service is exposed'. The following risks were identified in the Safeguards of Liberty audit report 2022/23:

Risk 1 - Failure to prepare for the revised changes may result in the Council failing to provide an appropriate service and safeguard and protect vulnerable/at-risk individuals. This risk was highlighted on the basis of a failure to prepare for a change in legislation. The UK Government's target date for the implementation of the LPS and the Mental Capacity (Amendment) Act 2019 had not been confirmed at the time. The Welsh Government announced in April 2023 that the UK Government had announced their intention to step away from the introduction of the LPS and implement the Mental Capacity (Amendment) Act 2019 (the 2019 Act). However, the Welsh Government provided £8m of funding in 2022/23 to support preparations for the LPS. As the regulations and Code of Practice have not yet been finalised, a significant amount of that funding has been used to provide training on the Mental Capacity Act and to manage the existing DoLS system. The UK Government gave an update on the issue in October 2025, stating that it will consult on the introduction of the LPS, alongside the code of practice of the Mental Capacity Act 2005.

Risk 2 - The Council is penalised for non-compliance with legal Laws relating to DoLS. The conclusion was based on the fact that a large backlog of DoLS applications existed and none were completed within the 21-day legal timeframe. Since, a DoLS Co-ordinator was appointed in 2022/2023, and the process has been reviewed and several new procedures have been introduced which have reduced the backlog of DoLS applications. This is reflected in the DoLS assessment completion statistics which appear to have increased in the last 3 years as follows:

Year(s)	2023	2024	2025
Total DoLS applications/assessments Completion	198	203	348

5.2 From the assessments checked, it appears that all contain documents loaded onto the electronics files on WCCIS with an assessment by the Doctor, the Best Interest Assessors and the approval.

5.3 While average implementation dates remain over the legal timeframe, including urgent requests, it appears that the percentage of assessments completed has increased. The Coordinator expressed that the applications are prioritised on an age basis, implementing claims under the age of 90 first rather than going on the date of the application was received. Even though the Service is not implementing in compliance to the legal timeframe which means they are at risk of fines, the issues is not isolated to the Council, the problem exists across the country.

However, the Service is committed to managing the risk by prioritising the applicants of younger ages, as from experience, it is believed that applicants of older ages (90+ years) are likely to be in residential care for an extended period, have relocated from their homes due to safety reasons or possibly without a home and are therefore not urgent applications. In addition, it was noted that applications with a relevant person representative (RPRs) through an agent/paid are more likely to refer the application to the court than those that have family members/relatives as a representative.

5.4 Due to the postponement of the implementation date of LPS, it was accepted that no plans had been put in place for preparation for the implementation of LPS until a target date of implementation had been determined.

5.5 The Coordinator was found to be accountable to the Assistant Head of Safeguarding, Quality Assurance, Mental Health and Community Safety and responsible for receiving, arranging, directing and distributing DoLS applications received through the Service's mailbox. It was seen that the applications were uploaded to the WCCIS system by the Administrative Assistant and the operational status was updated by the Coordinator. There were several stages where the Coordinator has complete control over the operation and information. With so few experienced staff and limited resources, there is a risk of over-reliance on one officer, until they are able to train new officers for the role. In addition, there does not appear to be a staff manual for implementing DoLS processes in place that adds to the risk of overdependence. Due to the limited resources, there are shortcomings in the controls such as failure to act on segregation of duties when approving invoices and examples have been seen where an officer has prepared and approved payments to themselves.

5.6 It appears from verifying a sample of payments made through the Payments Service that some payments have been made to Council staff. The Coordinator explained that these are payments for best interest assessments carried out by social workers outside of their working hours, as well as those carried out by the Coordinator herself. The Coordinator explained, with a shortage of assessors, that the process was introduced to clear the DoLS backlog. The Coordinator expressed that she is responsible for directing assessments to staff but is anticipated to end after March 2026. Following new appointments of two Best Interest Assessor Officers and training arrangements put in place, it is anticipated that additional staff will not be needed to carry out assessments outside of their working hours. However, tax implications must be considered if any similar payments are made in the future.

5.8 The Coordinator keeps a list of assessments that have been carried out by Doctors and Best Interest Assessors, and also if the application required procurement of an advocate or independent representative. The payments can therefore be reconciled back to the list of the Coordinator’s assessments. However, the Coordinator explained that regular checks and reconciliations of payments are not being carried out which can mean that there is a possibility of duplicate payments being paid without staff knowledge.

6. Actions

The DoLS Service is committed to implementing the following actions to mitigate the risks identified:

- **The Service is continuing with new arrangements in place and staff training to reduce the number of backlog applications.**
- **Train staff to relieve some of the Coordinator's responsibilities from over-reliance on one member of staff. Segregations of duties can then be established for processing payments and maintaining reconciliations.**
- **Any payments from assessments conducted by staff are subject to tax.**

Appendix 9

FLEET – FUEL CONSUMPTION

1. Background

1.1 The Council's fleet assists various departments in providing a wide range of services to the people of Gwynedd, including waste collection and road maintenance, and this is managed by the Fleet Service. The fleet includes electric cars, fossil fuel vehicles, vans, minibuses, and waste collection lorries.

2. Purpose and Scope of the Audit

2.1 The purpose of the audit was to ensure that the Council's vehicle fleet was safe and that their use was effective. To achieve this, the audit covered reviewing the systems in place, the monitoring reports and outputs produced, reviewing policies for compliance, tender arrangements, and ensuring that licensing, safety inspections and insurance arrangements were appropriate, as well as ensuring that proper arrangements for fuel management were in place.

3. Audit Assurance Level

3.1 The controls for risk mitigation were examined. The auditor's assessment concludes that the level of assurance of the audit is as follows:

Assurance Level	Description
LIMITED	**Although controls are in place, compliance with the controls needs to be improved and / or introduce new controls to reduce the risks to which the service is exposed.**

4. Current Risk Score

4.1 The audit's risks are as follows:

Risk Level	Number
VERY HIGH	0
HIGH	6
MEDIUM	1
LOW	0

5. Main Findings

5.1 The fleet Service relies on two main systems for vehicle management, along with two separate systems to monitor and manage fuel use. At the time of the audit, it was found that the fleet tracking system was in the process of being further developed to integrate new tracking units that will be installed on vehicles in the near future. There is an intention for the new system to be integrated with other systems, in order to provide a more comprehensive picture of fleet operations.

5.2 It was observed that the fleet vehicle tracking system automatically sends emails to managers on the system to notify them when employees are speeding. When reviewing the report from the system for the period between 19 October 2025 and 19 January 2026, around 1,000 cases were seen where drivers had travelled 60% or more over the speed limit. It was noted that some individuals appeared multiple times, but it was discovered that the system occasionally showed errors, which limits its reliability. The Fleet Manager was asked about the use of these reports and explained that it is the responsibility of Service managers to address these issues with their employees, and there is no assurance that follow-up actions are taken or any practical use is made of the information. It was explained that there is an intention to have an individual profile for each driver in the future, including a risk score and a record of any offenses. This will enable the Service to identify drivers who need intervention, training, or further support.

5.3 No other reports, except for cases of speeding, are generated from the system. As a result, and unless individual monitoring is carried out on every driver, it is impossible to confirm whether a driver has been driving for too many hours, or if there is personal use outside of work, etc.

5.4 The Fleet Manager confirmed that it is not possible to turn off the tracking units in the vehicles, but that several of the tracking units had failed. The fleet tracking system was checked and it appears that at least 88 vehicles have not been tracked since 2023 or earlier, suggesting that these are unlikely to be operational.

5.5 It has been noted as one of the Fleet's policies; "An employee who drives on Council business is responsible for always using an identification card when using one of Cyngor Gwynedd's vehicles and presenting their driving licence as required." The fleet tracking system was checked for the First week of February 2026, and it was found that there were over 150 instances where no identification card was used.

5.6 Several policies are available relating to fleet vehicles, such as 'Safe Driver', 'Safe Vehicle', 'Safe Journey', 'Refuelling Vehicles', and the 'Fleet and Occupational Road Risk Policy'. Responsibility lies with the Service Managers to ensure that staff read them, but there is no certainty that this happens. It was explained that the intention is to place the policies on a tile on the intranet to ensure easier access to them.

5.7 A sample of 10 vehicles was checked from the fleet asset system, and it was found that each had received a safety inspection within the year, with a current MOT test.

5.8 The procedure for dispensing fuel from the Council's supply into vehicles was checked, and it was found that each vehicle has an individual fuel tag. Drivers need to present the tag to the sensor on the fuel system and enter the current odometer reading. The Fleet Manager confirmed that the 'Jigsaw' fuel system checks and identifies that the reading is correct using the information stored from the last time the vehicle was refuelled. This control prevents drivers from deliberately under-declaring, but some cases were seen where inadvertent errors are made and it is necessary to contract the Fleet department to resolve them.

5.9 The ‘AllStar’ fuel system is used for staff who use an external fuel supply. In such cases, a bank card linked to the vehicle must be used to fill up with fuel, paying with a unique PIN. Drivers can enter any amount of fuel. Reports are sent directly to the Finance department, and retrospective checks are carried out in all cases. The Fleet Manager confirmed that he approves requests made through the bank cards, but the Fleet Service intends to merge this system with the ‘Jigsaw’ system to ensure a more consistent process and the ability to automatically raise any issues.

5.10 A sample of 5 trips/vehicles was checked in order to verify the recorded mileage and fuel taken. There were no records available in the fuel system for 1/5, but the other 4 were checked

5.11 The Council has begun using the external company DAVIS to carry out regular checks on driving licenses. It appears that only the Highways, Engineering, and YGC department, together with parts of the Environment department, have started implementing these new arrangements, due to higher risk factors associated with the use of heavy vehicles, but the hope is that all departments will adopt this system in the near future.

5.12 It appears that there is no system for managing and monitoring electric vehicles. As a result, the current arrangements suffer from unclear responsibilities, lack of oversight, and clear accountability. Information on charging is available on the Swarco system, but no officer monitors the information. There are no messages on the system, and no tracking units are currently installed on the electric vehicles, although these are being developed by the IT Service along with the new tracking units. There was no current list of all charging points available for the entire Council, and it appears that a number of charging points in schools have not been connected and therefore not being used.

5.13 There is no right to make any personal use of the Council’s fleet vehicles. However, some officers take the vehicles home, depending on the requirements of their jobs. It is the responsibility of managers to monitor the use of the vehicles, and due to the current lack of monitoring, there is a risk that some users may make personal use of the vehicles.

5.14 Several of the Council’s fleet vehicles have been informally allocated to specific departments. However, not every vehicle is used every day, and cars are often seen parked unused. As a result, when a staff member from another department requests a vehicle, the Fleet Manager must hire a vehicle for them, even though other vehicles are available but not being used. This can lead to unnecessary additional costs for the Council. The Fleet Manager has prepared a document on a new model to monitor the usage levels of each vehicle to ensure that the services truly need the vehicles, but no further discussion has taken place with Senior Officers so far

6. Actions

The Fleet Service has committed to implementing the following steps to mitigate the risks highlighted.

- **Establish a new vehicle tracking system (including a platform and new units), and incorporate it as part of the Council's Fleet Management System.**
- **Ensure that driver identification arrangements are addressed when upgrading the tracking system and installing new equipment.**
- **Establish robust monitoring arrangements for overrun reports and establish guidelines for managers.**
- **Publish a new tile on the Council's intranet that includes the policies and procedures of the Fleet Service.**
- **Identify who is responsible for vehicle charging systems by establishing clear ownership and responsibilities, along with developing tracking systems to include electric vehicles.**
- **Review and discuss the Council's vehicle financing models and set expected usage levels.**

Appendix 10

STREET CLEANING OVERTIME FOLLOW UP

1. Background

1.1 An Internal Audit of Street Cleaning Overtime was carried out as part of the 2024/25 plan, to ensure that suitable arrangements were in place for administering street cleaning and street bin emptying timetables in Gwynedd, as well as verifying processing arrangements and validating overtime requests. A limited level of assurance was given to the audit, that is to say, although controls were in place, compliance with the controls needed to be improved and/or new controls introduced to reduce the risks to which the service is exposed.

2. Purpose and Scope of the Audit

2.1 The purpose of the audit was to ensure that the agreed actions resulting from the latest full audit were implemented in a timely manner to mitigate the risks identified. To accomplish this, the audit covered the verification of records and supporting documentation.

3. Audit Assurance Level

3.1 The controls for risk mitigation were examined. The auditor's assessment concludes that the level of assurance of the audit is as follows:

Assurance Level	Description
SATISFACTORY	**Controls are in place to achieve their objectives but there are aspects of the arrangements that need tightening to further mitigate the risks.**

4. Current Risk Score

4.1 The audit's risks are as follows:

Risk Level	Number
VERY HIGH	0
HIGH	0
MEDIUM	4
LOW	0

5. Main Findings

5.1 Of the 14 actions agreed from the original audit, 9 were found to have been implemented, the conclusions are reported below. As a result, a revised agreed action plan was presented. It is noted that the Street Services Manager has retired since the full audit, with the CCTV and Street Scene Manager having taken over his duties.

5.2 It was reported that the service was very disappointed with the new 'Bartec' system. It was discovered a few months ago, before the system was operational, that it would not meet their requirements in terms of optimizing operations. It was confirmed that they were assessing different options to best fit the requirements of the service. However, it was noted that their work with 'Bartec' was not a complete waste, and that an interactive map identifying all the service's assets is now in their possession.

5.3 The timesheets of employees from all areas were checked for the period June 16th 2025, up to July 31st 2025, which is a period similar to that reviewed in the full audit. Workers in the Meirionnydd area were found to continue to start work before 5:00 a.m., which is contrary to Health and Safety requirements, with some starting as early as 3:00 a.m. The CCTV and Street Scene Manager confirmed that he had reminded the workforce not to do this verbally in October 2025, and again in writing during the Christmas period.

5.3 Similarly, there have been several occasions across the areas of staff members not confirming start and end times, with a number of timesheets not approved. It was also found that there is no distinction of duties when approving Team Leader timesheets in Caernarfon, where the signature of the member of staff and the approver is identical. A review of the Team Leader's payslip for July 2025 revealed that overtime had been paid at different pay rates, as expected, with any cleaning work being paid on the scale of 'Cleaner' not 'Team Leader'.

5.4 It was agreed in the full audit to trial changing the frequency of cleaning of some areas to reduce the demand for overtime. It was explained that this had happened in Dwyfor, Bangor, and Meirionnydd, but that it was not a success, with litter accumulating, and residents complaining, so they had to return to the normal cleaning schedules. Nevertheless, the CCTV and Street Scene Manager confirmed that alternative arrangements were planned

5.5 Although it was possible to purchase a second truck for waste collection, eliminating the need for 12-hour shifts, it was explained that the service’s budgets did not allow for the purchase of a vehicle capable of separating recycling waste. To avoid exacerbating the problem, it was noted that the service is no longer installing recycling bins on the streets of Gwynedd.

5.6 It was reported that the service now has a Group Accountant, and that they meet, and receive reports monthly. The service was found to have been successful in their bid to increase the staffing budget to include members of staff who had not been considered in the budget at the time of the full audit.

5.7 Compared to 2024/25, overtime expenditure in 2025/26 in the Arfon area was found to have decreased by £16,305, Meirionnydd by £20,067, and Dwyfor by £16,461, with 2025/26 staff overspend projected to be around £88,558 compared to an overspend of £275,305 in 2024/25.

5.8 While there is some work to be done to procure an effective system, and to tighten the monitoring arrangements for requests for overtime, it seems that the service has been successful in their efforts to reduce overtime expenditure without compromising the quality of work.

6. Actions

The relevant officers are committed to implementing the following actions to mitigate the risks highlighted:

- **Ensure that the Service acts upon the current operational tracking system, creating regular monitoring reports for data analysis and ensuring their appropriateness in terms of effective and efficient operation.**
- **Establish arrangements to monitor that staff do not start work before 5:00 a.m.**
- **That any overtime requests are checked for accuracy, and appropriately approved.**
- **Consider alternative options to enable the purchase of a vehicle that will allow the separation of recycling waste.**

Appendix 11

CATEGORY MANAGEMENT - ENVIRONMENT FOLLOW UP

1. Background

1.1 An Internal Audit of Environmental Category Management was carried out as part of the 2024/25 plan, to ensure that the Council spends public money in a strategic and appropriate manner. To achieve this, the audit included a review of a sample of contracts to examine the Council's development of environmental category plans and to confirm that the Category Team prioritises value for money and retains benefits locally.

2. Purpose and Scope of the Audit

2.1 The purpose of the audit was to ensure that the agreed actions arising from the most recent full audit have been implemented in a timely manner to mitigate risks. To achieve this, the audit included reviewing records or supporting documentation.

3. Audit Assurance Level

3.1 The controls for risk mitigation were examined. The auditor's assessment concludes that the level of assurance of the audit is as follows:

Assurance Level	Description
LIMITED	**Although controls are in place, compliance with the controls needs to be improved and / or introduce new controls to reduce the risks to which the service is exposed.**

4. Current Risk Score

4.1 The audit's risks are as follows:

Risk Level	Number
VERY HIGH	0
HIGH	1
MEDIUM	1
LOW	0

5. Main Findings

5.1 Four actions were agreed as part of the original audit in April 2025, one with a risk score of 6, two with a risk score of 12, and one with a risk score of 9. It was found that the actions had been partially implemented and the findings are reported below, however, ongoing work is in place to develop systems in order to prioritise value for money and retain benefits locally. As a result, a revised agreed action plan was prepared.

5.2 The original internal audit identified that one of the risks to be mitigated was a failure to properly maintain and manage a register of all contracts to ensure they receive timely attention. The service intended to transfer all contracts to the K2 system so that contract status could be monitored, including identifying when relevant documents need to be renewed. However, the K2 system has not yet been fully developed, and the Highways, Engineering and YGC Department is currently the only department using it. It does not appear likely that development of the K2 system for use by other departments can begin for several months due to departmental workload. As a result, the Environmental Category Management Team decided to begin trialling a PowerApp system to monitor accreditations of contracted companies and their subcontractors, to ensure company details remain up to date. The intention is for the PowerApp system to go live by April 2026.

5.3 To date, the Environmental Category Management Team has transferred a list of subcontractors to the PowerApp system, along with the Tree Management framework as a starting point. Further work is required to fully develop the system, and a significant amount of time will be needed to input all relevant information and contracts. Once completed, the system will allow access to company contact details, contract status, accreditations, start and end dates, records of social benefits, insurance details, and any essential documents that require renewal. The system will flag expired documents and send automatic email notifications to companies. It is intended to establish a tile for each contract on the PowerApp system and share these with relevant departments once the system is fully implemented.

5.4 During the original audit, the Environmental Category Management Team intended to transfer all arrangements to the K2 system. However, it now appears that the K2 system is not suitable for all frameworks and contracts across all departments. Although the Highways, Engineering and YGC Department currently uses the K2 system, it requires individual licences, which can create barriers for managers in other departments. In contrast, the PowerApp system can be shared with all staff without such restrictions.

5.5 Another risk raised during the original audit was the potential failure to comply with the new Procurement Act 2023, which came into force in February 2025. The Act introduced several requirements to be embedded within processes, along with mandatory training for staff. The training status of members of the Environmental Category Management Team was reviewed, and evidence was received that one member of staff had completed the Government's "Transforming Public Procurement" course, with another officer currently working through the modules. However, one member of staff had not yet started the training due to absence but intends to begin the training in March 2026. In addition, the Category Team Manager has arranged for the Environmental Category team to attend further training (Pass Procurement) once a date becomes available.

5.6 Following a request from the Highways, Engineering and YGC Department, a training session was delivered to the Department's Management Team on 17 July 2025. Evidence was seen that the session provided information on the Council's procurement rules and arrangements, ensuring that all attendees had the same basic understanding of procurement. The session also highlighted the changes introduced by the Procurement Act, ensuring staff were aware of the new arrangements now in force. The Procurement Service confirmed that it is willing to provide this training to any team that requires it, and the Highways, Engineering and YGC Department has requested further sessions. The Procurement Service is currently developing a presentation for the Highways and Engineering teams, with the intention of delivering sessions shortly. YGC has also requested a further presentation, and a session has already been delivered at the beginning of February.

5.8 Corporate training is also underway, including the "Procurement and Contracting" training available on the Council's Learning and Development Framework. The Procurement Service confirmed that consultation with the Category teams will take place prior to the session, so that they are aware of and familiar with the content and can provide relevant comments and input. In addition, "Social Value and Sustainability" training is being provided to procurement officers, and the Category Management Team has already attended one of these sessions. The intention of the Procurement Service is to develop more training in the future to strengthen procurement understanding and skills across the Council.

6. Actions

The Environmental Category Management Team and the Procurement Unit have committed to implementing the following actions to mitigate the risks identified:

- **Analyse expenditure to obtain a complete overview of contracts for the purposes of the full work programme.**
- **Continue to develop the PowerApp and K2 systems so that they are fully operational, and agree which contracts are most suitable for each system before transferring all contracts and associated monitoring activities.**
- **Arrange for all members of the Category Management Team to undertake and complete the Government's "Transforming Procurement" e-learning modules in a timely manner.**
- **Continue to develop further training in the future to improve procurement understanding and skills across the Council.**
- **Conduct random checks on a sample of contracts to ensure that the correct procedures have been followed and provide corrective action or intervention where appropriate.**

Appendix 12

BANGOR CREMATORIUM

1. Background

1.1 Bangor Crematorium works with funeral directors to provide a professional service for families during difficult times. As the only crematorium in Gwynedd, it is open every Monday to Friday, and on Saturday mornings on request.

2. Purpose and Scope of the Audit

2.1 The purpose of the audit was to ensure that suitable arrangements were in place for the management and maintenance of Bangor Crematorium in accordance with relevant regulations and standards. To accomplish this, the audit encompassed visiting the crematorium and reviewing that arrangements were adequate in terms of administration and staffing, receipt of income, and health and safety.

3. Audit Assurance Level

3.1 The controls for risk mitigation were examined. The auditor's assessment concludes that the level of assurance of the audit is as follows:

Assurance Level	Description
SATISFACTORY	**Controls are in place to achieve objectives but there are aspects where tightening of the arrangements is expected to further mitigate the risks.**

4. Current Risk Score

4.1 The audit's risks are as follows:

Risk Level	Number
VERY HIGH	0
HIGH	0
MEDIUM	3
LOW	0

5. Main Findings

5.1 The crematorium was visited on Thursday, 5th February 2026, in the presence of the Crematorium Team Leader. The establishment was well presented and the staff friendly and helpful. The cremation room was being renovated, with 2 new cremators installed and a new office created. As expected, the area was somewhat dusty, but this did not affect the operations of the crematorium, with the cremators, equipment and implements, and the preparation areas clean and orderly.

5.2 It was found that the crematorium's Visitors' Book was not located at the main entrance, but rather in the kitchen/staff room, located at the rear of the building. For access, a code must be entered at the door, with all staff members aware of it. It is noted that this door also allows access to the cremation room. On the morning of the visit, it was found that the door was not locked, and that it was possible for anyone to gain entry. It was explained that the door was kept open to allow access to the contractors working in the cremation room. It was confirmed that the door would be locked before the first service of the day, when the public would be on site. The door was found to be locked by the first service. As for the Visitor Book, although several visitors have signed it in the last month, the contractors working on the site do not. At least 3 workers were seen during the visit. It was suggested that the Crematorium Team Leader ask the contractors to sign the book from now on, considering moving it closer to the main entrance - it was agreed that the book be relocated to the office near the main entrance.

5.3 The training records of all staff at the crematorium were checked on the Gwynedd Jobs System prior to the visit. It appears that no one had completed fire training in the last 5 years, and only the Crematorium Team Leader has current First Aid training. Certificates were seen during the visit confirming that everyone had completed fire training in November 2025, and that the Administrative Assistant had recently completed First Aid training. The Crematorium Team Leader explained that members of staff had experienced difficulties in the past where training records, payslips etc were not updated on Cyngor Gwynedd's systems.

5.4 Only two of the crematorium's staff have completed most of the Council's mandatory E-learning modules, with none having accepted the Safeguarding policy. It was clarified that neither the Technicians nor the Caretaker have an email account to access the E-learning Portal or the Policy Centre, but that this will have to be arranged soon to be able to operate the new cremators. As for the rest of the staff, the Crematorium Team Leader confirmed that he would arrange for them to complete the modules and receive policies as soon as possible. By the time the Final Report was released, it was found that the Technicians had all received an email account.

5.5 It was found that the crematorium does not have a Fire Management Plan, and that tests on the alarm and fire extinguishers are not carried out in a timely manner on all occasions. The Crematorium Team Leader was surprised that a Fire Control Plan was not present in the blue box. However, it was clarified that the plan would have to be reviewed soon after the completion of the constructive work. Following the release of the Draft Report evidence was seen that the Municipal Asset Manager had shared the current plan with the Property service for review since July 2025, but no response was received. It was assumed at the time that the Property service reviewed the plan, placing a copy in the blue box, until the Auditor discovered that it was not present.

It was confirmed that the Municipal Asset Manager had contacted the Property service again following the audit to request an update, and in the meantime, had arranged to print a copy of the plan for the blue box.

5.6 Prior to the visit, a sample of 10 crematorium income transactions was selected between period from April to December 2025. 1 was disregarded as it was a payment relating to the cemetery and not related to a specific cremation. The accuracy of all relevant paperwork was reviewed, both internally and statutory, from the beginning of the process to the end, i.e. from receipt of an order from the funeral directors to receipt of payment and collection of ashes (where applicable). As expected, there are several forms to be filled, evidence needed, statements to be signed, necessary authorizations, and detailed record keeping involved. Apart from a failure to confirm cremation fees on one form (presumed acceptable given that the information was repeated on several other documents), the crematorium staff were found to be diligent, thorough, and took considerable pride in their work. All cremations in relation to the sample were well documented, with all relevant paperwork kept together. All documentation had been received within two days of the cremation, as expected, with the cremation itself having taken place on all occasions on the day of the service, payment having been made, and the ashes having been collected within a reasonable timeframe. On several occasions during the visit, staff would chat with funeral directors over the phone and face to face. On each occasion the conversation was respectful, but also friendly, a testament to the close working relationship developed over the years.

6. Actions

The Crematorium Team Leader is committed to implementing the following actions to mitigate the risks identified:

- **Ensure that any doors leading to restricted areas, e.g. the cremation room, are tightly always locked.**
- **Relocate the Visitor Book closer to the main entrance, ensuring that all visitors, including contractors, sign in and out.**
- **Remind staff to complete the Council's mandatory E-learning modules and to accept policies, arranging email addresses for any staff who need them.**
- **To make enquiries as to why the training of crematorium staff is not recorded on the Gwynedd Jobs System on all occasions.**
- **Ensure that, following the completion of the renovations, a new Fire Management Plan is drawn up, and kept in the blue box.**
- **Arrange for fire tests to be carried out in a timely manner on occasions when the responsible person is absent from work.**