

# Improving public service: a matter of principle





Parliamentary  
and Health Service  
Ombudsman

# Improving public service: a matter of principle

## First report

Session 2008-2009

Presented to Parliament pursuant to  
Section 14(4) of the Health Service Commissioners  
Act 1993 (as amended)  
and  
Section 10(4) of the Parliamentary Commissioner  
Act 1967

Ordered by  
The House of Commons  
to be printed on  
11 December 2008

HC9  
London: The Stationery Office  
£14.35

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ISBN: 9780102958348

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## Foreword

As Parliamentary and Health Service Ombudsman, I provide a service to the public by undertaking independent investigations into complaints that government departments, the National Health Service in England and a range of other public bodies in the UK have not acted properly or fairly, or have provided a poor service.

My Office has two key strategic objectives. The first is to help individuals who bring their complaints to my Office. I want to provide an independent, high quality and accessible complaint handling service that rights individual wrongs. The second key objective is to offer a wider public benefit. I consider it a fundamental part of my role to use the learning from my Office's 40 years of handling large numbers of complaints to help drive improvements in the delivery of public services and to help inform public policy. In order to do this I am committed to sharing as widely as possible the learning from the complaints I receive and to doing more to tell public bodies in my jurisdiction, including the National Health Service, about the value of dealing with complaints promptly and effectively. I also recognise the importance of making potential complainants, and those who support them, aware of my role and what I can achieve for them. For these reasons, I am publishing these case summaries which are the second set in an ongoing new series<sup>1</sup> of published summaries about complaints that I have investigated.

I have chosen these cases because they clearly illustrate good or poor practice in dealing with complaints from members of the public. In particular, the cases demonstrate how things might have been handled differently if the public

body concerned had had in mind the Ombudsman's three sets of Principles: *Principles of Good Administration*, *Principles for Remedy*<sup>2</sup> and *Principles of Good Complaint Handling*.

These Principles are broad statements of what I believe bodies within the Ombudsman's jurisdiction should be doing to deliver good administration and customer service, including offering remedy when things go wrong. The Principles cover:

- *Getting it right*
- *Being customer focused*
- *Being open and accountable*
- *Acting fairly and proportionately*
- *Putting things right, and*
- *Seeking continuous improvement.*

I fully appreciate that when public bodies deliver public services on a large scale, things will go wrong from time to time. What is key is how the public body then puts right the mistake. The Principles are not a checklist to be followed mechanically, but they do set out a framework for public bodies to have in mind. This will enable them to deliver a first class service to the public and offer the right approach to putting things right when they go wrong.

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<sup>1</sup> First in the series was *Remedy in the NHS*, June 2008

<sup>2</sup> [http://www.ombudsman.org.uk/improving\\_services/good\\_administration/](http://www.ombudsman.org.uk/improving_services/good_administration/)  
[http://www.ombudsman.org.uk/improving\\_services/remedy/](http://www.ombudsman.org.uk/improving_services/remedy/)

The *Principles of Good Complaint Handling*<sup>3</sup> is the third in the series of Principles. They were published in November this year, and build on the *Principles of Good Administration* and *Principles for Remedy*. The *Principles of Good Complaint Handling* set out how public bodies should manage complaints properly so that customers' concerns are addressed and dealt with appropriately. Complaint handling should be led from the top, focused on outcomes and accessible to the complainant. All too often I see cases where the complaint handling falls short of these entirely reasonable expectations. Mr S was left feeling frustrated and outraged following his experience with the Security Industry Authority, which sent his application form for a door supervisor's licence to someone else (page 45). The Authority initially failed to explain their complaint process, failed to keep accurate records and did not put things right quickly and effectively.

In the case of Mrs Y (page 14), a GP Practice failed to act on a Consultant's letter, and compounded that by not responding to Mrs Y's complaint about that matter, having initially insisted that they had dealt with her complaint.

Complaints are also a valuable source of feedback for the public body. Handled well, they provide an opportunity for public bodies to improve both their service and their reputation. That means addressing individual complaints but also fixing underlying problems and using the feedback and learning to improve performance. Moreover, good complaint handling can save time and money and may result in fewer complaints.

The cases in this report come from a range of public bodies within my jurisdiction, including the

National Health Service. They show the Principles in practice, for example what we mean by '*Acting fairly and proportionately*', or by '*Being open and accountable*'. In the case of Mrs C's complaint about continuing care funding for her friend, Mrs J, for example (page 9), we considered that the Trust and Strategic Health Authority had not acted fairly since their portrayal of health needs did not provide evidence of Mrs J's healthcare needs drawn from all the available and relevant evidence; and had not been open or accountable since they had not clearly explained how the funding decision had been reached and what evidence had been used.

The Principles show what can happen when things go wrong and what can be done to prevent mistakes happening again in the future. The cases highlight where the Principles might have been used to good effect to improve the outcome for the complainant. I would like to emphasise that we have chosen these cases only to illustrate what we mean by the Principle concerned.

Many of the cases highlight where public bodies fail to put things right properly and do not take decisions based on all relevant considerations. When Jobcentre Plus suspended Mr K's income support payments following a request from him to pay him by cheque, they left him without money for three weeks (page 61). They rightly considered the question of a financial remedy for Mr K, but then did not consider the full impact of their actions on him.

The three sets of Principles represent common sense and good practice but I hope they also go further than that, to drive a shared understanding about what makes for good administration and excellent service and complaint handling in public

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<sup>3</sup> [http://www.ombudsman.org.uk/improving\\_services/complaint\\_handling/](http://www.ombudsman.org.uk/improving_services/complaint_handling/)

bodies and the National Health Service. I hope that using the case studies to illustrate the Principles will help prevent mistakes of the past being repeated and will encourage public bodies to use the *Principles of Good Administration*, *Principles for Remedy* and *Principles of Good Complaint Handling* to offer a better service to the public. Complainants often say that they hope that others will benefit from their complaint. I share that hope. This set of case summaries is intended to enable others to benefit from the learning from these individual complaints, as public bodies translate that learning into a better service for all.

A handwritten signature in black ink that reads "Ann Abraham". The signature is written in a cursive, flowing style.

Ann Abraham  
**Parliamentary and Health Service Ombudsman**

December 2008



# Complaint about Rotherham Primary Care Trust and South Yorkshire Strategic Health Authority (now Yorkshire and the Humber Strategic Health Authority)

## *Flawed consideration of an application for retrospective continuing care funding*

### Background to the complaint

Mrs J was admitted to a nursing home on 10 November 1999 following a fall in September 1999 in which she fractured her hip. She also suffered from dementia and transient cerebral ischaemia (temporary neurological problems caused by interrupted blood flow). She was transferred to a second nursing home in November 2003 and remained there until she died on 5 September 2004.

Mrs J's friend, Mrs C, applied for NHS continuing healthcare funding on Mrs J's behalf in April 2003. The Local Review Panel of Rotherham Primary Care Trust (the Trust) considered Mrs C's claim. It concluded that Mrs J was not eligible for continuing care funding from 10 November 1999 to 3 August 2004, but from 4 August 2004 her condition '*became more unstable and complex*' and she was thus eligible for funding from that date until her death. Mrs C appealed to South Yorkshire Strategic Health Authority (the Authority) about the decision. The Continuing Care Appeal Panel, held on 22 November 2004, upheld the decision of the Local Review Panel.

In January 2005 Mrs C complained to the Ombudsman about the Authority's decision. We investigated and recommended that the Authority thoroughly review Mrs J's case. The Trust subsequently completed a portrayal of Mrs J's healthcare needs and a second Local Review Panel was convened to reconsider Mrs C's claim. The Panel concluded that Mrs J did not meet the eligibility criteria for continuing care funding before 4 August 2004.

### What we investigated

In May 2007 Mrs C complained again to the Ombudsman that Mrs J had not been assessed for continuing care funding at any time she was resident in the nursing homes. She said that the Trust had not compiled a robust and accurate portrayal of Mrs J's healthcare needs and, in particular, that the summary of needs had given insufficient attention to the end stage gangrene from which Mrs J suffered, and which required the involvement of a tissue viability nurse.

We considered whether the Trust's review process met the following expectations set out in the *Principles of Good Administration*:

- '*Getting it right*' (acting in accordance with the public body's policy and guidance – published or internal).
- '*Being open and accountable*' (being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete; and stating criteria for decision making and giving reasons for decisions).
- '*Acting fairly and proportionately*' (ensuring that decisions and actions are proportionate, appropriate and fair).

In the context of retrospective continuing care complaints this is taken to mean that there will have been:

- a robust portrayal of health needs, drawn from all the available and relevant evidence;
- a fair, proportionate and reasonable process of assessment/review which is inclusive of relatives and carers;

- consideration of the person's individual healthcare needs by an appropriately constituted and qualified panel, and comparison of these healthcare needs to the eligibility criteria; and
- a decision conveyed to the claimant that clearly explains how it was reached, the evidence used and the rationale.

We examined all the relevant documentation. We also took advice from an experienced nurse with considerable experience of continuing care reviews and assessments.

#### What our investigation found

We found that the needs portrayal did not provide evidence of Mrs J's healthcare needs between 2000 and 2002, and significant events recorded in the portrayal concerning tissue viability and nutrition from 31 March 2004 were not reflected in the summary and did not appear to have been considered by the Panel. There was no reference in the Panel report to any of the contemporaneous records to support the statement that Mrs J was not eligible for funding before 4 August 2004. We found that Mrs C had not been given a clear explanation for how the decision was reached, the evidence used and the rationale for the decision.

In summary, the Trust's review process was flawed and for that reason we upheld Mrs C's complaint. The investigation was concluded in May 2008.

#### Outcome

As a result of our recommendations:

- the Trust agreed to apologise to Mrs C for not having thoroughly reviewed Mrs J's case; and
- Yorkshire and the Humber Strategic Health Authority (as the Authority's successor) agreed to ensure that a robust re-review of Mrs J's case would be undertaken.

#### *Principles of Good Administration*

The following *Principles of Good Administration* were referred to in this case summary:

- '*Getting it right*' (acting in accordance with the public body's policy and guidance – published or internal).
- '*Being open and accountable*' (being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete; and stating criteria for decision making and giving reasons for decisions).
- '*Acting fairly and proportionately*' (ensuring that decisions and actions are proportionate, appropriate and fair).

# Complaint about the Healthcare Commission

## *Flawed investigation of a patient's complaint about a dentist*

### Background to the complaint

On 18 June 2004 Mr G attended a dental practice (the Practice) for a routine examination. He saw Dr L, whom he had not seen before. By Dr L's account, during the examination she noticed that Mr G was suffering from sensitivity in the lower left part of the mouth, and that the filling in the lower left second permanent molar tooth (LL7) may have been leaking. She advised Mr G that it needed replacing. Mr G returned for the planned treatment on 5 July. Dr L anaesthetised the lower jaw, but before the dental work began, Mr G told Dr L that the sensitivity was in the upper left part of his mouth, and that this was where he had understood dental work was going to take place. Dr L found that the upper left part of the mouth was sensitive to cold air, and she administered anaesthetic in the upper left part of the mouth. She replaced a filling in the upper left second molar tooth (UL7), but did no work on the LL7 tooth. By Dr L's account she indicated to the reception staff that a further appointment was needed for the work on the LL7 tooth.

### Complaint to the Practice and to the Primary Care Trust

In July 2004 Mr G complained to the Practice that Dr L had administered an unnecessary anaesthetic in his lower left mouth. In her reply, Dr L explained that she had done so because during the 18 June examination she had found that the filling of the LL7 tooth needed replacing. She said that Mr G had first mentioned sensitivity in the upper left part of his mouth on 5 July. Dr L said that rather than go ahead and restore the LL7

tooth on 5 July, she had administered anaesthetic to the upper left part of his mouth and repaired the UL7 tooth instead. Mr G complained to the Primary Care Trust, disputing Dr L's account of events.

### Complaint to the Healthcare Commission

Mr G then complained to the Healthcare Commission (the Commission), which took advice from its Dental Adviser (the Dental Adviser). The Dental Adviser referred to the General Dental Council's publication *Principles of Patient Consent* and the *National Health Services (General Dental Services) Regulations* (the Regulations). He took the view that providing a written treatment plan to all patients returning to a dental practitioner was a professional requirement under the guidance in *Principles of Patient Consent*, and that providing a written treatment plan was a requirement for all dentists under the Regulations. The Dental Adviser concluded that Dr L had failed to obtain Mr G's consent on 18 June to repair the lower filling and his consent to administer anaesthetic in the lower part of his mouth. In reaching this finding, the Dental Adviser considered Mr G's dental notes for the consultation of 18 June, in which it was recorded that he had complained of sensitivity in the lower part of his mouth and that a filling had been prescribed for the LL7 tooth. He also noted Mr G's assertion that what he had actually been complaining about was pain in the upper left area. The Dental Adviser concluded that although it was '*one word against another*', it was his professional opinion that Dr L had not '*adequately secured*' Mr G's consent to administer the anaesthetic as Mr G was '*probably unaware that Dr L had prescribed a filling*' in the lower part of his mouth. The Commission accepted the advice of the Dental Adviser and

upheld Mr G's complaint. It recommended to Dr L that she apologise to Mr G and suggested changes to her working practices.

A Senior Dento-Legal Adviser at Dental Protection (Mr B) wrote to the Commission on Dr L's behalf. He contended that some of the advice given by the Dental Adviser was factually incorrect, and that the decision that Dr L had not obtained patient consent was not supported by the evidence. At the time Dr L had examined Mr G, the Regulations relating to treatment plans did not stipulate that a plan was necessary when a patient was transferred from one dentist to another in a practice under a continuing care arrangement. The Regulations only required a dentist to provide a plan if carrying out three or more permanent fillings or any other specified treatments. Mr B pointed out that the *Principles of Patient Consent* had only come into force around one year after the events complained about. He argued that Dr L had neither a statutory nor ethical obligation to provide a written treatment plan. However, it was unlikely that she would not have told Mr G about the treatment he was to undergo, having recorded the outcome of the 18 June examination. The Commission obtained further clinical advice and replied, apologising for '*the distress caused by the provisions cited*'. Its position remained that the '*consent [was] not as robust as it could [have been]*'.

### What we investigated

Mr B complained to the Ombudsman that the Commission's findings about the treatment plan were inaccurate and flawed, and its finding about consent was incorrect and unjustified.

We investigated whether the Commission's investigative process was flawed, and had led to an unreasonable decision. We studied the papers provided by Mr B and the Commission, and took clinical advice from our own Dental Adviser.

### What our investigation found

We found that the Commission did not adequately explore or explain why Mr G's case required a written treatment plan, and that the additional material used in the consideration of this aspect of this case (*the Principles of Patient Consent*) post-dated the June 2004 consultation.

We had concerns about the basis of the Commission's conclusion about consent, as it was not clear why it had given more weight to Mr G's account than to that of Dr L. Given the absence of a clear explanation – and the view of the Commission's Dental Adviser that this aspect of the complaint rested on '*one word against another*' – we did not consider that the basis for the Commission's conclusion was adequately or persuasively explained. The Commission's response to Mr B's complaint about its report was cursory and superficial. Although it took additional clinical advice in response to his representations, its subsequent response did not address Mr B's specific points. Moreover, although that response was less critical of Dr L than before, the Commission's recommendations to her remained unchanged. It was disappointing that the Commission did not take the opportunity presented by Mr B's complaint to resolve matters before it came to the Ombudsman. Had the Commission shared a draft of the report with Mr B – thereby giving him the opportunity to comment – it is likely that the issues he identified would have been brought to its attention much

earlier, and would have stood a better chance of being satisfactorily addressed at the time.

The Commission's investigation was maladministrative and we upheld Mr B's complaint. Our investigation was concluded in April 2007.

### Outcome

At our recommendation, the Commission agreed to:

- reconsider Mr G's complaint and review its recommendations (and consider if any tangible recognition of its failings was appropriate for Mr G or Dr L as a result); and
- apologise to Dr L for the failings we had identified.

### *Principles of Good Administration*

The *Principles of Good Administration* were not referred to in our report but this case summary serves to illustrate the following Principles:

- '*Getting it right*' (taking reasonable decisions, based on all relevant considerations).
- '*Acting fairly and proportionately*' (treating people impartially, and ensuring decisions and actions are proportionate, appropriate and fair).
- '*Putting things right*' (acknowledging mistakes and apologising).



# Complaint about a General Practitioner

*Inadequate responses to a letter from a hospital Consultant about a patient's medication and to a letter of complaint from the patient's wife*

## Background to the complaint

Mrs Y's late husband (Mr Y) was severely disabled with a chronic obstructive pulmonary disorder (a condition that results from damage to the breathing tubes and air sacs within the lungs). He was a patient of Dr Z at a GP Practice. In May 2005 a hospital Consultant (the Consultant) wrote to the Practice, suggesting changes to Mr Y's medication. The Consultant's Specialist Registrar saw Mr Y in August, when it transpired that Dr Z had not acted upon the Consultant's letter. Mr Y's prescription was changed after the Specialist Registrar wrote to the Practice.

## Complaint to the Practice and to the Healthcare Commission

In September 2005 Mrs Y delivered a letter of complaint to the Practice about Dr Z's failure to act upon the Consultant's letter. Despite the intervention of the local Primary Care Trust, the Practice did not respond. In January 2006 Mrs Y referred her complaint to the Healthcare Commission, which was unable to complete its review due to the Practice's lack of co-operation.

## What we investigated

The Healthcare Commission referred Mrs Y's complaint to the Ombudsman, who exercised her discretion to investigate the complaint as it stood. Sadly, Mr Y died in June 2006.

We investigated the Practice's failure to take action on the Consultant's letter and failure to respond to Mrs Y's complaint about that. We examined the available documentation, and took clinical advice from a General Practitioner.

## What our investigation found

Dr Z was responsible for ensuring that his Practice had effective procedures for dealing with correspondence. Although we could not establish the precise sequence of events, it appears that after receipt at the Practice, the Consultant's letter was probably filed in Mr Y's notes without being referred first to Dr Z. We concluded that the Practice did not have a robust procedure in place to record and respond to such letters.

Our clinical advice was that it would have been desirable for the Practice to have implemented the Consultant's suggested changes, and if the Practice had done so without delay, then this could have helped Mr Y's breathlessness, reduced the rate of exacerbations (a sustained worsening of the patient's symptoms from their usual stable state, which is beyond normal day-to-day variations and is acute in onset) and improved his quality of life. It was unlikely, though, that the three-month delay in changing Mr Y's prescription altered his long-term prognosis.

Since 1996 GP surgeries have been required to operate their own complaints procedures, in line with national guidelines. Dr Z had ultimate responsibility for ensuring the Practice had an acceptable procedure in place to handle and monitor complaints and that staff were trained to operate that procedure efficiently. We would have expected the Practice Manager to manage the complaints procedure for Dr Z (as she does now). The Practice initially said they had replied

to Mrs Y's letter, but could not produce a copy of their reply. However, the Practice later admitted that, essentially, they had ignored Mrs Y's complaint and did not reply. The Practice Manager's evidence indicates that the letter was filed away without being date-stamped or seen by Dr Z. We criticised the Practice for not responding to Mrs Y's complaint and condemned them for misrepresenting the truth by initially insisting they had replied to her complaint.

These failings left Mrs Y with little choice but to pursue her concerns through other routes. This prolonged her dissatisfaction and distress at a time when she was naturally concerned for her husband's health. It also meant that she had to wait longer than necessary for an independent explanation about the impact of the delayed change to her husband's medication on his health.

During our investigation, Dr Z told us that his own *'lack of experience in the NHS Complaints Procedure'* led to his *'totally inadequate and incorrect'* handling of Mrs Y's complaint. He wrote to her, apologising unreservedly for the unacceptable handling of her complaint, and offered to meet her, to offer an honest and thorough account of his management of her husband. He apologised that an oversight had apparently delayed the start of Mr Y's new medication and concluded that the Practice had learnt from their mistakes. Having considered Dr Z's letter, Mrs Y told us that she felt that his apology was insincere and too late, and reiterated her view that her husband might have lived longer had Dr Z changed his prescription promptly. She declined the meeting offer, saying that she would prefer a written explanation of his management of her husband.

We upheld Mrs Y's complaint and concluded our investigation in August 2007.

## Outcome

We recommended that Dr Z:

- write to Mrs Y, offering her a full and honest explanation for the Practice's failure to act on the Consultant's letter and her complaint; and
- pay her £250 in recognition of the distress and inconvenience the Practice's poor complaint handling had caused.

We noted the action that Dr Z had taken (and planned to take) as a result of Mrs Y's complaint, in particular his intention to attend NHS complaint handling courses and to set up a Practice system to ensure that the same mistake cannot recur. In support of that, we recommended that Dr Z ask the Primary Care Trust to consider his proposed action plan, to help him to make any changes considered necessary in light of our findings, and to implement and monitor it.

Dr Z agreed to implement our recommendations.

### *Principles of Good Administration*

The *Principles of Good Administration* were not referred to in our report but this case summary serves to illustrate the following Principles:

- *'Being open and accountable'* (taking responsibility for actions).
- *'Putting things right'* (acknowledging mistakes and apologising).
- *'Seeking continuous improvement'* (learning lessons from complaints and using them to improve services and performance).

# Complaint about the Healthcare Commission

## *Remedy for a flawed investigation and poor service*

### Background to the complaint

In November 2002 Mrs S fractured her femur. She was admitted to St George's Healthcare NHS Trust (the Trust) and underwent a dynamic hip screw procedure (insertion of metal plate and screws into the leg in order to allow healing of the fractured upper thighbone). In January 2003 the Trust X-rayed the fracture; Mrs S says she was told *'it had mended ok'*. A further X-ray was taken in February; the doctor was said to be pleased with the fracture. In March Mrs S decided to have private physiotherapy; in connection with that she paid privately for an X-ray. It showed the fracture had not united.

### Complaint to the Trust and to the Healthcare Commission

In November 2003 Mrs S complained to the Trust. She asked why no one had pointed out that the fracture had not healed and why the X-rays had not picked up that the fracture had not mended. The Chief Executive replied in January 2004. He said his Consultant Orthopaedic Surgeon had said that fractures unite once they are healed and that X-rays sometimes suggest fractures have healed when they have not. Dissatisfied with that response, Mrs S wrote to the Trust's Convenor. The Trust's final response of March 2005 reiterated the Consultant's previous advice about X-rays.

Before Mrs S received the Trust's final response, she complained to the Healthcare Commission (the Commission). The Case Manager reviewed her complaint and sent her a decision letter on

8 July 2005 saying that he had referred her complaint back to the Trust, and asked them to obtain an independent orthopaedic opinion on her X-rays. (The Trust were unable to do that because Mrs S's complaint had been discussed by the whole orthopaedic team. The Commission agreed to obtain an independent opinion instead.)

In February 2006 the Commission asked a Consultant Orthopaedic Surgeon (the Clinical Adviser) if the Trust's explanations to Mrs S were *'accurate and adequate'*. The Case Manager sent a second decision letter to Mrs S on 11 April, saying that Mrs S had received correct and appropriate surgical treatment, but that he had concerns about how the Trust had communicated with her and supplied information to her. The Case Manager said that the Clinical Adviser had *'commented that he believed [the X-rays] were suggesting a good progress regarding healing of the bone but sometimes a computerised tomography (CT) scan may be needed to rule out any abnormality in the healing process'*. He concluded the Trust had *'responded appropriately with regard to the interpretation of your x-rays'*. Mrs S replied that her concerns had not been addressed; she asked for confirmation of whether her X-rays did, or did not, show a break. The Commission agreed to review its previous decision and sought clinical advice from a second Clinical Adviser.

A final decision letter was sent to Mrs S in April 2007 by the second Case Manager, who relayed the second Clinical Adviser's opinion that fractures of the type Mrs S had suffered took about three months to heal solidly but sometimes took a lot longer. He said the second Clinical Adviser had explained that an X-ray taken in December 2002 showed *'the fracture remains in excellent position'* and that the X-ray taken in

January 2003 showed *'the position of the fracture remained the same. He noted that ... one would not expect the fracture to be healed at this point. He stated that the reason for the X-ray was to see if the fixation remained secure and the fragments remain the same [sic] position relative to each other'*. The second Case Manager said a further X-ray taken in February 2003 *'confirmed the results were the same as shown on the film taken on January 15 2003'*. He stressed that Mrs S's fracture had healed appropriately.

The second Case Manager conveyed to Mrs S the second Clinical Adviser's advice about: the visibility of fractures and fracture healing on X-rays; why X-rays might not show breaks; and CT scans. He also informed her that the fracture had been clearly visible on all the X-rays reviewed by the second Clinical Adviser. He said *'in the opinion of the adviser, the reason for taking the films had been to check the position of the fracture and only secondarily (at that early stage) to assess healing ... the reason you were advised that things were going well ... was because they were, but this related to the maintenance of the fracture position'*. The second Case Manager concluded that there was nothing further that the Commission could do (or that the first Case Manager should have done), and proposed to take no further action.

### What we investigated

Mrs S complained to the Ombudsman in May 2007 that after two reviews by the Commission she had still not received answers about whether the Trust's X-rays showed a break, or why the Trust failed to identify that her fracture had not mended. She also complained that the Commission's reports contradicted each

other, and was unhappy about the length of time the reviews had taken. Mrs S said the delays had prolonged the inconvenience and distress she had suffered.

We investigated the Commission's handling of Mrs S's complaint, to assess whether its investigation process was flawed, its service poor or its decision wholly unreasonable. We also looked at whether it took an unreasonably long time to review her complaint.

During the investigation we examined all the relevant documentation and obtained specialist advice from a Consultant Orthopaedic Surgeon.

### What our investigation found

The Commission's decision letter of April 2007 included a detailed interpretation of the Trust's X-rays, and stated that Mrs S's fracture was visible on them all. We therefore disagreed that the Commission had failed to answer her questions about whether or not the X-rays showed the break. Neither did we agree that the Commission's reviews had failed to address why the Trust did not identify that Mrs S's fracture had not mended: the same letter confirmed that the X-rays would not have been expected to show that it had healed, and that she was told things were going well (in January and February 2003) because they were. The second Clinical Adviser provided clear and detailed advice about the course of healing of fractures and about the interpretation of the X-rays, and correctly identified that the fracture had mended appropriately.

However, we criticised the Commission's conclusion that there was nothing further that it could do, or that the first Case Manager should

have done. The Commission should have obtained its own clinical advice at the outset in response to Mrs S's complaint (rather than first asking the Trust to do so). That failure meant that her concerns were not resolved at the earliest opportunity, and so prolonged the inconvenience and distress she suffered. The Commission's decision letter of 11 April 2006 did not give Mrs S a clear answer about whether her X-rays showed a fracture. Furthermore, having previously identified that the Trust needed to take further action to address her concerns about the X-rays, the Commission now concluded that the Trust had responded appropriately. We therefore found that the decision letters of 8 July 2005 and 11 April 2006 appeared contradictory. The Commission took an unreasonably long period of time (29 months) to complete its reviews and provide Mrs S with a response that addressed her concerns.

In summary, the Commission's investigative process was flawed and its service was poor, and these failings amounted to maladministration. Furthermore, the Commission did not demonstrate it met the standards of behaviour expected of it, as outlined in the *Principles of Good Administration* ('*Being customer focused*' – keeping to its commitments, including any published service standards; '*Being open and accountable*' – giving information that is clear, accurate and complete; and '*Putting things right*' – putting mistakes right quickly and effectively).

We partly upheld Mrs S's complaint and concluded our investigation in June 2008.

## Outcome

At our recommendation, the Commission agreed to:

- apologise to Mrs S for the failings we had identified; and
- pay her £200 as compensation in recognition of the inconvenience and distress its delay in resolving her complaint had caused her.

### *Principles of Good Administration*

The following *Principles of Good Administration* were referred to in this case summary:

- '*Being customer focused*' (keeping to commitments, including any published service standards).
- '*Being open and accountable*' (giving information that is clear, accurate and complete).
- '*Putting things right*' (putting mistakes right quickly and effectively).

# Complaint about Pennine Acute Hospitals NHS Trust and the Healthcare Commission

*Complaint about care and treatment after two operations were cancelled and about poor complaint handling*

## Background to the complaint

Mr V was being treated by Pennine Acute Hospitals NHS Trust (the Trust) for sleep apnoea (a condition where the patient stops breathing during sleep) and a Consultant Surgeon (the Surgeon) put him on a waiting list for examination under anaesthetic. On 13 September 2002 he attended for the surgery, but was sent home. This was because the anaesthetist deemed him to be a high risk and required that he undergo a formal pre-operative assessment, including an echocardiogram, and because he would need a High Dependency Unit (HDU) bed. By the time Mr V was discharged, he had been without food or drink for about 20 hours.

On 4 October 2002 Mr V attended for pre-operative assessment, but his medical notes were unavailable. He said he tried to tell the staff about the tests that were required but they did not listen to him. When Mr V attended for the rearranged operation on 14 October, staff identified that he had not undergone the required tests. An echocardiogram was carried out but, as an HDU bed was not available, the operation was cancelled. On 11 November Mr V saw the Surgeon, to discuss the problems he had faced, but felt rushed and the issue of relisting his surgery was not resolved. Mr V's progress continued to be monitored, and in April 2003 a 'watch and wait' policy was adopted in respect of his future treatment.

## Complaint to the Trust and to the Healthcare Commission

In November 2002 Mr V complained to the Trust. In reply, the Trust explained why the operations had been cancelled and apologised for the inconvenience and anxiety caused. In March 2003 Mr V complained to the Trust, via his representative. He wanted to know why he was kept at the Trust on 13 September for so long; why staff had ignored what he told them about the tests required by the anaesthetist; and why he waited so long on 14 October when similar staff had dealt with him on 13 September. Mr V also complained about the Surgeon's attitude during the November consultation, which had left him feeling unimportant and angry. The Trust's response did not cover all the issues.

A local resolution meeting took place in October 2003, but Mr V remained unhappy. The Trust issued their final response in March 2004, apologised for their complaint handling, said that the complaints system was being externally reviewed, repeated their previous explanations and said they could do nothing more. The Trust told Mr V that he could request an independent review (but not that he had to do so within 28 days of the local resolution ending). After a review had been requested on 29 July, the Trust told Mr V's representative that it was too late for him to request one.

Mr V complained to the Healthcare Commission (the Commission). Its recommendations to the Trust included that they give Mr V a more detailed explanation for the October cancellation, and tell him about the steps being taken to improve their complaint handling. No further action was taken on the complaint about the Surgeon. Mr V was dissatisfied with the information later provided by the Trust.

## What we investigated

In August 2006 Mr V complained to the Ombudsman seeking explanations for the failings he had experienced, and financial redress for the impact that pursuing his complaint had had on him.

We investigated the Trust's cancellation of Mr V's operations and his subsequent care; the events that occurred at the pre-operative assessment; and their complaint handling. We also investigated Mr V's complaint that the Commission had not investigated all his concerns and had ignored his evidence.

We looked at all the relevant documentation, and took clinical advice from an experienced Surgeon.

## What our investigation found

We found that it was unreasonable that Mr V had waited so long at the Trust in September 2002 before being told that his operation had been cancelled, and that the delay could have been avoided if his medical records had been reviewed earlier. The Trust apologised to Mr V for this failure and improved their systems as a result. The anaesthetist did not record his decision that Mr V was a high risk, and why. If Mr V was a high risk and needed an HDU bed, the Trust had failed to organise this before admission. The lack of an adequate record of why the operation was cancelled and the failure to get a statement from the anaesthetist meant that the Trust could not provide a clear reason for the cancellation.

It was unreasonable that Mr V's medical records were unavailable for the pre-operative assessment (the Trust have since improved their systems). The Trust said that the lack of medical records had no

impact on the quality of the assessment and Mr V's ongoing care, but also said this meant no echocardiogram was performed, leading to the cancellation of the October operation. These views were contradictory and we criticised the Trust for their unclear explanations. There was a lack of planning before Mr V's October admission, and a delay in telling him that the operation had been cancelled.

It was not possible to determine what occurred at the consultation with the Surgeon. As he had previously apologised to Mr V for the communication breakdown, we did not investigate the matter further.

The Trust's complaint handling was poor. Their responses to Mr V were delayed and did not fully answer his concerns. He had difficulty contacting staff to discuss his complaint and there was confusion about the review. The Trust misunderstood Mr V's complaint, believing it was mainly about system failures, whereas he wanted to know why he was a high anaesthetic risk. If the Trust had given Mr V clear explanations about that the complaint may not have reached the Ombudsman. In summary, the Trust's failings significantly impacted on Mr V's life in terms of distress and inconvenience and we upheld his complaint.

The Commission failed to obtain independent clinical advice on Mr V's complaint, although it raised clinical issues. It failed to scrutinise the Trust's explanations, and so unfairly presumed that they had given Mr V an adequate and accurate account of his care and treatment. Mr V's concerns that the Commission's decision letters were unfair and biased were understandable. It would have been better for the Commission to have confirmed with Mr V the complaint to be investigated (the Commission

now does this). Its review focused on the changes in practice at the Trust rather than on the facts of the complaint. Furthermore, the lack of clinical advice affected the quality of explanation given to Mr V and the appropriateness of its recommendations. We found that the Commission's complaint handling was maladministrative, and denied Mr V an independent review of his complaint. We upheld the complaint.

We concluded our investigation in July 2007.

#### Outcome

The Trust and the Commission agreed to implement the following recommendations:

- The Commission and the Trust were to apologise to Mr V for the failings we identified.
- The Trust were to pay £250 to Mr V in light of the serious failings in their complaint handling; and to report back to the Ombudsman on how the lessons learnt from this case have been fed into their practices and procedures.

As the Commission was already working with the Trust to improve their complaint handling, no further recommendations were necessary.

#### *Principles of Good Complaint Handling*

The *Principles of Good Complaint Handling* were not referred to in our report but this case summary serves to illustrate the following Principles:

- *'Being customer focused'* (ensuring people can easily access the service dealing with complaints; listening to complainants to understand the complaint and the outcome they are seeking).
- *'Being open and accountable'* (providing honest, evidence-based explanations and giving reasons for decisions; keeping full and accurate records).

# Complaint about a Dental Practice and a Dentist

## *Inappropriate dental care and inadequate complaint handling*

### Background to the complaint

On 20 February 2006 P, then aged seven, was taken to a dental practice (the Practice) by his father, Mr A. He was seen by Dr H who carried out fillings to two baby molar teeth. Mr A remained with his son during treatment. At around lunchtime, P began complaining of pain to his lip. The inside of the mouth was lacerated. Mr A returned to the Practice with P, where he was examined by Dr H and a colleague (the Second Dentist). He was referred to hospital, and examined by a Consultant. P needed stitches.

### Complaint to the Practice and to the Healthcare Commission

The same day, Mrs A complained to the Practice that she believed the laceration had been caused by a drill used by Dr H when treating P. In his reply, Dr H said he believed that the laceration had been caused by P biting his lip while it was anaesthetised. He explained that the Second Dentist had pointed out the shape of P's teeth imprinted over the wound. He was sure that the laceration had not been caused in the Practice.

On 28 February 2006 the Practice Manager told Mrs A that Dr H was returning to Germany. In March the local Primary Care Trust (the Trust) told Mrs A that Dr H had not left a forwarding address, and suggested that she might involve the Healthcare Commission (the Commission). Mrs A duly referred her complaint to the Commission in March. In response to Mrs A's complaint and a subsequent request by the Trust, P was examined by the Dental Reference Service (part of the clinical

governance arrangements for NHS dentistry). The Dental Reference Officer concluded in his report of 10 April that the restoration was confluent (meaning that the fillings were placed in the two teeth as one filling), and he advised that the restoration would need to be replaced to allow for individual tooth movement. He also identified further visible decay at two other baby molar teeth. Later, Mrs A told the Commission that P had developed a massive abscess in the teeth that Dr H had filled, which had then been removed under general anaesthetic.

Because of the perceived complexities caused by Dr H's relocation abroad, the Commission asked the Ombudsman to accept Mrs A's complaint for investigation. The Ombudsman agreed to do so.

### What we investigated

We investigated whether the laceration to P's lip had been caused by Dr H's drill; whether the fillings installed by Dr H were substandard; and whether the Practice had handled Mrs A's complaint appropriately.

We studied the available documentation, including P's dental records, and discussed the complaint with Mrs A, Dr H and the Practice Manager, and contacted the Dental Nurse present on 20 February, along with the Second Dentist. We asked the Consultant for his opinion and studied the medical records taken for P while he was under his care. We also saw the photographs of P's lip taken by the family and sought clinical advice from two Dental Advisers.

### What our investigation found

The laceration to P's lip was significant. The Consultant thought the trauma was '*considerable*'

compared with bite injuries he had seen, but was not absolutely certain that the injury was caused by a drill. Our own clinical advice was that if the injury had been caused during the appointment, the wound would probably have bled significantly. That would have been very apparent at the time, or at least sooner than a few hours later; it was *'most likely'* that P had bitten his lip. The Second Dentist believed he witnessed impressions of P's front teeth on his lower lip. We could not reconcile the different opinions and, on balance, we could not be certain that P's injury was not self-inflicted.

The standard of care provided by Dr H to P was not wholly appropriate. Our clinical advice highlighted that it was *'poor quality dentistry'* to have installed confluent fillings, and it was noted that there was a justifiable need for X-rays to be taken before the fillings were installed (which would almost certainly have picked up the decay found by the Dental Reference Service).

Although the Practice Manager told Mrs A that Dr H was leaving the Practice, we saw no evidence that Mrs A was told what action she could take under the NHS complaints procedure if she remained dissatisfied with the Practice's response to her complaint. The Practice's *Code of Practice for Patient Complaints* advises patients to approach the Patient Advice and Liaison Service if they are not satisfied. Whilst that signposting was helpful, the Code of Practice was misleading and inaccurate as it did not advise patients of their right to contact the Commission if dissatisfied with the Practice's response to their complaint. Mrs A could have been advised more appropriately about what to do next.

We concluded our investigation in February 2008, and partly upheld Mrs A's complaint (we did not uphold the complaint about P's lip laceration and

upheld the complaints about the care provided to P and the Practice's complaint handling).

### Outcome

The Practice agreed to amend their Code of Practice to reflect the provisions of the NHS (Complaints) Regulations which advise on the Commission's role.

Dr H agreed to:

- review the Ombudsman's report and reflect on the learning points identified;
- send Mrs A a written apology for the shortcomings in his restorative dentistry practice; and
- identify an appropriate person under his working arrangements abroad and share our findings and conclusions with them as part of his ongoing appraisal, and learning and development process.

### *Principles of Good Complaint Handling*

The *Principles of Good Complaint Handling* were not referred to in our report but this case summary serves to illustrate the following Principles:

- *'Being open and accountable'* (publishing clear, accurate and complete information about how to complain, and how and when to take complaints further).
- *'Seeking continuous improvement'* (using all feedback and the lessons learnt from complaints to improve service design and delivery).

# Complaint about Heatherwood and Wexham Park Hospitals NHS Trust (now Heatherwood and Wexham Park Hospitals NHS Foundation Trust), Berkshire East Teaching Primary Care Trust (now Berkshire East Primary Care Trust) and the Healthcare Commission

## *Complaint about the care and treatment of an older person and about subsequent complaint handling*

### Background to the complaint

In March 2003 Mrs U, then aged 83, collapsed and was admitted to Wexham Park Hospital (Wexham Park), managed by Heatherwood and Wexham Park Hospitals NHS Trust (the Trust). She saw Dr G, who suspected a cardiac condition. He arranged for a 24-hour ECG (electrocardiogram) and an echocardiogram. Mrs U was discharged, although her niece (Mrs T) said she was weak and had dizzy spells. A few days later Mrs U was admitted to Heatherwood Hospital (Heatherwood), also managed by the Trust. A head scan found no abnormalities. Mrs U was discharged, but collapsed on 17 April, fracturing her ankle. She was readmitted to Wexham Park, where Dr G diagnosed possible drop attacks (short blackouts that result in falls) and prescribed Epilim Chrono, an anticonvulsant medication.

Mrs U had ankle surgery at Wexham Park on 20 April 2003 and her leg was put in a cast. She was transferred first to Heatherwood and then, on 3 May, to Upton Hospital (Upton), managed by Berkshire East Teaching Primary Care Trust (the PCT) for rehabilitation. Mrs U was due to have an out-patient appointment with Dr G on 20 May, but a week earlier Upton had cancelled the appointment (and did not schedule a further appointment) because she was an in-patient with them and was therefore under the care of a consultant on the ward. (At the time, Mrs T was told that the appointment had not been

cancelled and that Mrs U had not been offered another appointment because she had failed to attend the clinic on 20 May.)

In June 2003 Mrs U was transferred back to Wexham Park, having developed a vascular ulcer on her ankle. Her cast was removed and the wound was found to be infected. Mrs U was treated with intravenous antibiotics. A swab for MRSA was negative. She went back to Upton on 10 June. A further 24-hour ECG was carried out on 1 July, whilst Mrs U was still largely confined to bed. A swab for MRSA then proved positive and Mrs U was readmitted to Wexham Park. She was later transferred back to Upton, and discharged in mid-July. By Mrs T's account, Mrs U's dizzy spells and weakness continued. She was suffering from hair loss and a bad taste in her mouth; possibly side-effects of her medication. Mrs U went for an EEG (electroencephalogram) at Charing Cross Hospital in August, the results of which are unknown. However, Mrs U's GP contacted Mrs T on receiving the results, having diagnosed a heart problem. An ECG taken in September showed Mrs U had a complete heart block (no connection between the atrial and ventricular beats of the heart). The Royal Brompton Hospital fitted her with a pacemaker and she remained on Epilim Chrono until some time in October.

### Complaint to the Trust and to the PCT

Mrs T complained to the Trust in September 2003 about delay in diagnosing Mrs U's heart condition, the prescription of Epilim Chrono and the lack of review of the medication. She was dissatisfied with the Trust's response and made additional complaints about delay in placing Mrs U's EEG

results on her records, the care of the ankle wound, the development of MRSA, and the arrangements for the May 2003 out-patient appointment. A local resolution meeting took place in June 2004, after which the Trust told Mrs T that some of her complaints had not been answered at the meeting, because they involved Upton. The Trust asked the PCT in July 2004 for a response to the issues that related to Upton, and sent a final response in October.

#### Complaint to the Healthcare Commission

Mrs T then complained to the Healthcare Commission (the Commission). Because Mrs U's medical records were confirmed as lost by the Trust, the Commission could only view the limited records from Mrs U's GP and the Royal Brompton Hospital. Its subsequent report to Mrs T addressed all of her complaints, apart from the appropriateness of carrying out a 24-hour ECG test when Mrs U was immobile. The Commission upheld a number of Mrs T's complaints and recommended that the Trust review their policies and systems for booking follow-up orthopaedic appointments and tracking clinical records.

#### What we investigated

Mrs T complained to the Ombudsman in January 2007 that she had not received adequate explanations about Mrs U's care and treatment from the Trust, the PCT and the Commission. She was also concerned that the Commission could not make findings in some areas because of the loss of Mrs U's medical records. Mrs T wanted to know what had gone wrong with Mrs U's care and treatment and wanted the Trust 'taken to task'

for the delays in investigating her complaint and for losing the medical records.

Because of the loss of Mrs U's medical records, we decided to investigate the substance of Mrs T's complaints against the Trust and the PCT, as well as the Commission's handling of her complaint. We investigated ten issues of concern to Mrs T which were that:

- the Trust delayed diagnosing Mrs U's cardiac problem;
- the Trust inappropriately prescribed an anticonvulsant, which was not monitored or stopped when Mrs U was diagnosed with cardiac problems;
- the Trust delayed placing Mrs U's EEG results on her medical notes;
- the Trust and PCT failed to cancel Mrs U's May 2003 appointment;
- Trust and PCT staff failed to examine Mrs U's broken ankle at regular intervals;
- a 24-hour ECG was carried out on Mrs U when she was immobile;
- Mrs U's ankle wound became infected with MRSA;
- the Trust lost the medical records during the Commission's investigation;
- the Trust's investigation of Mrs T's complaint was unhelpful and slow; and
- the Commission's investigation and explanations were unsatisfactory.

The only clinical evidence available was contained in letters from the Trust and PCT to Mrs U's GP, and the records relating to her treatment at the Royal Brompton Hospital. Limited clinical information was contained in the Trust's letters to Mrs T. We took clinical advice from a Consultant Physician and a Senior Nurse, both with expertise in the care of older people. The guidance we took account of included the *National Service Framework for Older People* (March 2001), and the NHS Modernisation Agency's *Essence of Care* (revised in April 2003).

#### What our investigation found

There was no evidence before late August 2003 that Mrs U had any significant cardiac problems, that her early treatment and investigations were inappropriate, or that she had a cardiac problem from the outset that was undiagnosed. The Epilim Chrono should have been stopped when her heart condition was identified. The Trust said that the prescription was reviewed at that point but, if so, that did not explain why the prescription continued for a month. A delay in placing Mrs U's EEG results on her medical records may have contravened the NHS code of practice on records management, but we could not say more without seeing the records. In any event, a delay would not have been clinically significant.

There was evidence that Upton had cancelled Mrs U's May 2003 appointment, and that she had not been removed from the clinic list. The Trust explained that they would not have made a further appointment automatically because Mrs U remained under the care of Upton, which would have indicated the timescale for a follow-up review upon discharge. A review appointment was said to have been arranged for 15 September at the request of the ward staff,

but we could not confirm that. The failure to arrange a follow-up appointment for the plaster cast to be checked was a significant failing. As Mrs U was transferred to Upton shortly after surgery, responsibility for carrying out the appointment lay with both the PCT and the Trust. We could not be certain what checks were carried out and when, but the cast was not removed until over a month after surgery. These facts, taken with Mrs T's account that Mrs U had complained of pain and a smell coming from her cast, strongly indicated that the checks were inadequate.

It was not inappropriate to carry out the ECG test when Mrs U's movement was restricted, as the results would show the same heart rhythm and rate. Without the records we could not comment definitively on the testing for and management of the MRSA infection, but the screening and isolation procedures appeared reasonable. The loss of Mrs U's medical records was a serious failing which had significant consequences for the investigation of Mrs T's complaints by both the Commission and the Ombudsman. The Trust's responses were slow and often contained little information, with few apologies or explanations for the delays. Mrs T was not told by the Trust until late in the proceedings that Upton was managed by the PCT.

The Commission's investigation was reasonable. It was slow to conclude, but that was partly because of matters beyond its control. The delays, in themselves, did not amount to maladministration. The Commission failed to address Mrs T's question about the 24-hour ECG test, which was unhelpful; our investigation has remedied that injustice.

What injustice flowed from the service failings and maladministration identified? The failure to

examine Mrs U's ankle appropriately led to her developing an ulcer; the failure to monitor her prescription following the diagnosis of her heart condition meant that she may have taken the drug for longer than necessary; and the loss of the clinical records deprived Mrs T of comprehensive answers to many of her complaints. The Trust's poor complaint handling meant that she did not receive a satisfactory resolution locally and had to involve the Commission and then the Ombudsman, causing additional inconvenience and delay.

We concluded our investigation in November 2007, and upheld Mrs T's complaints against the Trust and the PCT. We did not uphold her complaint against the Commission.

## Outcome

As a result of our recommendations, the Trust:

- re-examined the monitoring of Mrs U's medication and gave Mrs T an explanation;
- reviewed the handling of Mrs T's complaint and informed her about how the lessons learnt from this case were used in their review of their complaint handling process; and
- apologised in writing to Mrs T for the failings in their complaint handling.

In addition, the PCT provided Mrs T with an account of the lessons learnt from the failure to examine Mrs U's ankle wound in an appropriate and timely manner.

## *Principles for Remedy*

The *Principles for Remedy* were not referred to in our report but this case summary serves to illustrate the following Principles:

- *'Putting things right'* (considering fully and seriously all forms of remedy, such as an apology and explanations).
- *'Being customer focused'* (understanding and managing people's expectations and needs).
- *'Seeking continuous improvement'* (using lessons learnt from complaints to ensure that maladministration or poor service is not repeated).

# Complaint about Taunton and Somerset NHS Trust (now Taunton and Somerset NHS Foundation Trust) and the Healthcare Commission

*Complaint about the handling of a complaint regarding the alleged abuse of an older person following a hospital admission and about the Healthcare Commission's review*

## Background to the complaint

In February 2005 Mrs C, aged 79, was referred to Musgrove Park Hospital, having been unwell for a few weeks. She was extremely weak, unable to stand without assistance and her feet were very swollen and painful, owing to a related gout condition. She was diagnosed with bilateral hydronephrosis (swelling of both kidneys owing to a backup of urine); and bilateral nephrostomies (insertion of a tube through the skin into the kidney to provide urine drainage) were performed the next day. A suspected malignant lump was also found within Mrs C's pelvic region. However, she contracted an infection and she was considered too weak to undergo further investigation.

Over the next eight days Mrs C told her husband, Mr C, of several instances of poor treatment by staff: being refused help to use the commode; being ordered out of bed; being scolded for leaning on her bed for support; and being orally harangued and roughly handled by a member of staff during the night. After that last incident, Mr C contacted the Patient Advice and Liaison Service, and the ward Matron then met with Mrs C the same day and agreed to speak to the staff concerned. The Matron turned down Mrs C's daughter's request to stay the night. Mrs C died early the next morning.

## Complaint to Taunton and Somerset NHS Trust and to the Healthcare Commission

In March 2005 Mr C complained to Taunton and Somerset NHS Trust (the Trust); his letter focused on what he described as at least three instances of '*deliberate abuse*' towards Mrs C. In April 2005 the Trust replied, apologised for the distress caused, and said that the care afforded to Mrs C had been below standard and that the Matron and Ward Sister were working to improve, and then maintain, standards. Mr C was unhappy with the response, including the involvement of ward staff in investigating the complaint, and remained so following a meeting with the Trust in May 2005.

In June 2005 Mr C complained to the Healthcare Commission (the Commission). Its report was issued in November 2005, and made four recommendations to the Trust. Mr C said that the Commission had failed to address the complaint that his wife had been abused. Correspondence between Mr C, the Commission and the Trust continued (Mr C also met with the Trust again in March 2006). In September 2006 the Trust apologised for the fact that they had, in breach of their Employee Relations Policy, not involved the Human Resources department in considering the complaint. In November 2006 the Commission issued its second report, confirming that finding, and said that it saw no scope for further action.

## What we investigated

Mr C then complained to the Ombudsman. Our investigation looked at both the Trust's and the Commission's handling of Mr C's complaints. In his complaint to the Ombudsman Mr C said that the lack of resolution to his complaint continued

to cause him considerable distress and that *'I have the lasting memory of unnecessary suffering inflicted on my wife by those who were paid to care for her'*. He also referred to the time taken and expense incurred in pursuing his complaint.

During the investigation we considered evidence provided by Mr C as well as relevant documentation from the Trust and the Commission. We took clinical advice from a Senior Nurse.

In reaching our findings on this complaint we took into account the Trust's complaints policy. We also considered the Department of Health's guidance to support the implementation of the *National Health Service (Complaints) Regulations 2004* and their March 2000 guidance *No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse* (this latter guidance set out the requirement to have such a policy backed up by training for staff).

#### What our investigation found

We found that, despite the Department of Health's guidance, the Trust had no policy in place, in 2005, for managing concerns related to adult protection/vulnerable adults.

We found that the Trust's involvement of the Matron and other ward staff in the investigation of Mr C's complaint complied with their internal complaints policy.

We found that the Trust had been responsible for delays in their handling of Mr C's complaint and in their responses to the Commission.

We found that the Commission failed to confirm its understanding of the complaint with Mr C and did not, as a result, identify his main complaint: that the Trust had not properly addressed the complaint about abuse.

We found that the Commission did not consider the appropriate national guidance in investigating Mr C's complaint as it did not identify the lack of, or question the Trust about the existence and use of, a policy for managing concerns related to adult protection/vulnerable adults.

We found that the Commission wrongly investigated Mr C's complaint about the Trust's failure to follow their Employee Relations Policy despite it being a staff disciplinary matter and not, therefore, within the remit of the NHS complaints procedure. By doing so the Commission caused confusion and further delay.

The investigation concluded in April 2008. We upheld the complaints about both the Trust and the Commission. Mr C was caused distress and inconvenience by the failure to consider his complaints fully, properly and within a reasonable timescale.

#### Outcome

As a result of the Ombudsman's recommendations the Trust:

- wrote to Mr C to apologise;
- agreed to provide the Commission (in its regulatory role) with evidence about their performance against response times for complaints (the Trust having reorganised their complaints department since 2005). The Commission would also monitor performance

going forward and information arising from that would be copied to Mr C and the Ombudsman;

- developed an action plan to ensure the implementation of their Adult Protection/ Vulnerable Adult Policy (which was agreed by the Trust's Board in December 2007); and
- put funding in place for a new post of Adult Protection Supervisor.

As a result of the Ombudsman's recommendations the Commission:

- wrote to Mr C to apologise; and
- paid him £150 compensation for the distress caused by its failures.

### *Principles for Remedy*

The *Principles for Remedy* were not referred to in our report but this case summary serves to illustrate the following Principles:

- '*Putting things right*' (apologies and compensation).
- '*Seeking continuous improvement*' (using the lessons learnt from complaints to ensure that maladministration or poor service is not repeated; recording and using information on the outcome of complaints to improve services).



# Complaint about the Immigration and Nationality Directorate (now the UK Border Agency) of the Home Office

## *Remedy for unreasonable delays and mishandling of an asylum application*

### Background to the complaint

Ms A and her sister entered the UK in August 1998 and applied for asylum. They attended separate initial asylum interviews at the Immigration and Nationality Directorate (IND) in October. In July 2000 IND noted that Ms A's address had changed, but on 17 August they sent a statement of evidence form to her former address, to be completed and returned by 31 August. (IND sent a statement of evidence form to Ms A's sister at her correct address on the same day.) In September Ms A's representatives sent IND the completed statement of evidence form, which they said Ms A had received after the 31 August deadline. IND did not link the form to the file.

On 11 September 2000 IND refused Ms A asylum on the grounds that she had not returned the statement of evidence form by the deadline. On 19 September they issued the refusal letter and an appeal form. Ms A's representatives asked IND to reconsider their decision because the statement of evidence form had been sent to the incorrect address. They enclosed an appeal form (which IND received on 25 September). In January 2001 IND acknowledged they had sent the statement of evidence form to the wrong address. They notified Ms A that their decision of 11 September 2000 was withdrawn, and invited her to withdraw her appeal, which she did. IND received the withdrawal form on 12 February, but did not update their systems to show that the appeal had been withdrawn.

(Meanwhile, in November 2000 IND had conducted an asylum interview with Ms A's sister. They refused her asylum claim in January 2001.

Her subsequent appeal was heard in December 2001 and allowed in January 2002 – on human rights and asylum grounds. In February 2002 IND granted her indefinite leave to remain in the UK as a refugee.)

IND interviewed Ms A in July 2001 and refused her asylum application on 2 August. The file should then have been sent to an enforcement location to serve refusal, enforcement and appeal papers, but it was placed in a holding location instead. There is no record of any substantive action on Ms A's case between August 2001 and May 2003 when IND's Appeals Processing Centre called for her file. It appears that the previous appeal was considered to be 'reinstated' even though the decision and the appeal had been withdrawn. In August 2003 Ms A's Member of the European Parliament wrote to IND about the time taken to process her asylum application. IND did not respond.

Despite the fact that IND had not yet served the formal notice of the refusal of Ms A's asylum application, in January 2004 they served her with notice of a decision to issue removal directions against her. In February a local councillor asked IND for an update on Ms A's case, but again they did not respond. In June IND sent a bundle of appeal papers to a firm of solicitors with no involvement in Ms A's case. The substantive hearing of Ms A's appeal took place in August, when the Independent Adjudicator dismissed the appeal on asylum and human rights grounds. Ms A was granted permission to appeal. The appeal was heard in March 2005, and remitted for another hearing in June. In July her appeal was allowed by an immigration judge on asylum and human rights grounds. On 18 July IND decided not to challenge the decision.

From 30 August 2005 a new policy was introduced (under the Government's Five Year Strategy for Asylum and Immigration) whereby people recognised as refugees would initially be granted a period of five years' limited leave to enter or remain in the UK. On 23 September IND asked Ms A to provide passport photographs and to confirm various details. They received a prompt response and on 4 October they issued a status document granting Ms A leave to remain in the UK for five years, in line with the new policy.

In December 2005 Ms A's MP wrote to ask the Minister why Ms A had only been granted five years' leave, when her sister had been granted indefinite leave. The Parliamentary Under Secretary replied, apologising for the delay hearing Ms A's appeal and explaining that the sisters' asylum claims had been decided separately and assessed on the basis of information submitted in each case. He explained that Ms A could only be granted five years' leave, in accordance with the asylum policy effective from 30 August 2005, but could apply for further leave a month before her current leave was due to expire.

### What we investigated

Ms A complained to the Ombudsman in April 2006 that she had applied for asylum at the same time as her sister, but that as her sister's case had not been subjected to the same delays, she (her sister) had been granted indefinite leave to remain. Ms A said that IND had treated her unfairly and that their mistakes had put her in a worse position than her sister.

We investigated whether IND had delayed deciding Ms A's asylum application, and whether the time taken to process her successful appeal

and grant her leave to remain was maladministrative (as this spanned the critical period when the policy changed).

### What our investigation found

IND sent the statement of evidence form to an incorrect address and delayed attaching it to Ms A's file, which resulted in an incorrect refusal decision. They failed to issue an asylum refusal decision, with associated enforcement and appeal papers, following the refusal decision of 2 August 2001; processed an appeal which had been withdrawn because of a failure to update their systems; dispatched appeal papers to an incorrect representative; and did not reply to correspondence. IND also served a removal notice on Ms A when they had not yet served a decision relating to the application. Taken together these errors amounted to a serious failure on IND's part to get it right or to be customer focused, two of the *Principles of Good Administration*. That was maladministrative.

We did not uphold Ms A's complaint that IND had unreasonably delayed implementing the appeal decision. They knew the appeal outcome by 18 July 2005 and took 49 working days to ask for the information needed to prepare the leave to remain document. Although IND took longer than the average time taken to request the information (and longer than would be good administration), we did not regard the time taken as being so excessive as to be maladministrative.

The injustice to Ms A flowing from IND's maladministration was that she suffered uncertainty and anxiety, and would have been granted asylum significantly earlier than she was, and granted indefinite (rather than limited) leave to remain. IND contended that the time taken to

deal with Ms A's application was not unusual and that there was no guarantee of a successful appeal even if they had dealt with the application sooner. While we recognised that, over the period in question, IND had difficulty dealing with the number of asylum cases they received, the fact was that Ms A's sister's application took three and a half years to determine, while Ms A's application took over seven years. Ms A's appeal was ultimately successful; we saw no persuasive evidence to suggest that an earlier and more straightforward sequence of events would have led to a different outcome.

We concluded our investigation in April 2008 and partly upheld Ms A's complaint.

### Outcome

To remedy the injustice to Ms A, IND agreed to:

- apologise to her for the way they had handled her case and make a payment of £250 to recognise the inconvenience she suffered;
- grant her indefinite leave to remain in the UK; and
- reimburse the difference between the fees for making an application for citizenship in 2004 (which is when Ms A would have been able to apply) and the current fees (provided Ms A applied within a year of being granted indefinite leave to remain).

### *Principles of Good Administration*

The following *Principles of Good Administration* were referred to in this case summary:

- *'Getting it right'* (acting in accordance with the public body's policy and guidance; and taking proper account of established good practice).
- *'Being customer focused'* (dealing with people helpfully, promptly and sensitively).

Commenting on a draft of the Ombudsman's report, Ms A said *'let me take this opportunity to express my heartfelt thanks for your thorough investigation of my complaint. ... I look forward to the successful completion of this matter and start[ing] a new chapter in my life'*.

# Complaint about HM Courts Service

*Complaint about a breach of confidentiality by HM Courts Service as well as their subsequent handling of correspondence, a complaint and a request for compensation*

## Background to the complaint

In August 2006 Mr and Mrs M moved house because they had been threatened by the second of two defendants against whom Mrs M had brought civil proceedings. A decision had been taken not to prosecute that defendant in relation to the alleged threats and Mrs M had discontinued her case against that defendant (but not the other). However, Mr and Mrs M believed that the threat against them remained, which led to their decision to move.

Mr M wrote to HM Courts Service (HMCS), following a telephone call to them the previous day, supplying his new address on the understanding that it would not be disclosed outside the court or its staff, nor passed to either of the defendants or their representatives.

In September 2006 Mr M received correspondence at his new address from the second defendant's solicitors. Mr M raised this with the court. The defendant's solicitors said that a member of court staff had provided them with the address.

## Complaint to HM Courts Service

Mr M wrote to HMCS to complain. They said that no order had been made not to disclose the address, that they could not locate any member of staff who recalled disclosing it, nor find any evidence that they had done so. They also said that they had written to the defendant's

solicitors asking them not to give the address to anyone.

Mr M complained to the Area Director, relaying the advice he had been given before disclosing his address and saying that he had not been told that a court order would be required. He sought £18,000, covering damages from stress as well as costs.

In October 2006 Mr M reported being threatened close to his new home. HMCS wrote to Mr M and said that they could only make a payment if he had suffered financial loss as a direct result of an administrative error. They had seen no evidence that the solicitors had passed on his new address or that the court had given the address to them. They said the decision to move house had been Mr M's and he had provided no evidence of further incidents since his move. A judge had seen the letter requesting non-disclosure and had made no order.

Mr M wrote again and said that his claim regarded the court's breach of confidentiality (not an assumption of the information being passed on), that he had been threatened again and that, without a court order, HMCS had now implemented non-disclosure of the address. HMCS replied to Mr M saying that there was no evidence that his address had been supplied to the solicitors via the court and that any claim from him could not be considered without this.

Mr M wrote again; HMCS said they would reply by 22 December 2006. In December 2006 they wrote to his MP and said that Mr M's claim for compensation had been refused as it did not meet the criteria for payment. They said that there was nothing to prevent the address being disclosed when the solicitors rang the court, but

they had now removed the address from their system as a gesture of goodwill.

On 28 December 2006 Mr M received a letter saying that HMCS were seeking legal advice, which would take 28 days. Mr M complained that HMCS were breaching their service standards and had changed their position on several points in their letter to his MP, including now admitting to passing on the address. In January 2007 HMCS replied to Mr M and said there had been no maladministration by their staff.

In June 2007 HMCS gave Mr M's details to a bank. In August they apologised for this and said they should have contacted Mr M first.

### What we investigated

In August 2007 Mr M complained to the Ombudsman. We investigated Mr M's complaints that HMCS:

- committed a breach of confidentiality by disclosing his address;
- provided contradictory accounts of their actions in responding to his complaint;
- provided several different reasons for refusing his claim for compensation;
- failed to make him aware of the correct complaints procedure; and
- failed to meet service standards in replying to correspondence.

Mr M said that the actions of HMCS had nullified attempts by him and his wife to secure their personal safety by moving house. He said that

they were fearful for their wellbeing and had a minimal quality of life.

### What our investigation found

We found that HMCS failed to ensure that the advice they provided to Mr M was clear, accurate and complete. He was given misleading advice and he, not unreasonably, believed that his address would be kept confidential. Having failed to advise Mr M correctly, HMCS then breached his confidentiality by disclosing his address to the solicitors. We did not find that they disclosed Mr M's address to any party other than the solicitors and the bank.

We found that HMCS failed to deal with Mr M objectively and consistently by not reaching their final conclusion (about whether they had passed the address on to the solicitors by telephone) at an earlier stage.

We found that the criterion which HMCS used to judge whether to pay compensation remained essentially the same: did Mr and Mrs M incur financial loss as a result of an administrative error by court staff? We did not, therefore, find that HMCS were maladministrative in that respect.

We did not find any evidence that HMCS provided Mr M with their complaints procedure and it would have been good customer service for them to have done so. However, this did not hinder Mr M's ability to pursue the matter and they referred his complaints to the correct office within reasonable timescales. We did not therefore find that this omission caused any injustice to Mr M.

We found that it was reasonable for HMCS to have decided to seek legal advice in order to give

Mr M a proper response and this inevitably caused a delay. However, they sent Mr M clear holding letters in the interim. We did not find that any delay in handling correspondence amounted to maladministration.

We found that Mr M had very real concerns for his family's safety and that his distress was exacerbated by maladministration on the part of HMCS. We also found that Mr M had been caused additional frustration by their handling of the issue of whether they had disclosed his address to the solicitors.

Our investigation report, issued in February 2008, partly upheld Mr M's complaint.

### Outcome

As a result of our recommendations HMCS made a compensation payment of £500 to Mr M and sent him a written apology for the shortcomings identified in our report.

### *Principles of Good Administration*

The *Principles of Good Administration* were not referred to in our report but this case summary serves to illustrate the following Principles:

- '*Being open and accountable*' (ensuring that information, and any advice provided, is clear, accurate and complete).
- '*Acting fairly and proportionately*' (dealing with people and issues objectively and consistently).



# Complaint about the Disability and Carers Service (now the Pension, Disability and Carers Service) of the Department for Work and Pensions

*Decision to reduce disability living allowance award taken without proper consideration of all the relevant facts*

## Background to the complaint

Following a stroke in 1998, Mrs N received the highest rate care and higher rate mobility components of disability living allowance from September 1999. The award was made on the basis that she needed assistance during the day and help with going to the toilet at night.

In October 2004 Mrs N completed a form to renew her award from March 2005. Mrs N said that, periodically, she had epileptic fits, and that five nights a week she needed help with going to the toilet once a night. She also said that seven nights a week she needed help turning in bed and changing her sheets or night clothes. The Disability and Carers Service asked Medical Services to assess Mrs N's mobility and care needs. The doctor examined her in October. He was asked to write down on the form what Mrs N had told him in her own words. He said that she told him *'I move from room to room with the above said wheelchair'* and *'Sometimes if I can't wait for someone to come & help me to go to toilet I try to move a bit to micturate near the toilet...'* (pass urine near the toilet) and *'I am not incontinent'*. He wrote that Mrs N told him that at night-time she needed watching in case she got epileptic fits, but needed no help with toilet needs; and that she was mentally competent, and could not do anything for herself. He listed the medication that Mrs N took, but not how often she had to take it. Nor did he say when Mrs N had last fallen, a question to which he was asked to respond. The doctor wrote that, in his opinion, Mrs N could not turn over, or move position in bed and that, although she needed help with her

toilet needs at night, she did not require such help or help for any other purpose.

In December 2004 a decision-maker considered Mrs N's application, awarded her middle rate care component and refused the highest rate because: *'Although I accept that Mrs N has epilepsy and sometimes experiences a fit during the night, I do not consider that she would be at substantial risk of danger as she would be in her bed'*. Mrs N was notified of the decision and her appeal rights. Mrs N's daughter (Ms E) told us that her mother did not appeal because she had entrusted supervision of her financial affairs to her (Ms E). She had set up a bank account specifically to deal with her mother's benefits and care-related bills, and provided that the account was in credit she did not inspect the entries thoroughly. Ms E said that at the time the decision letter had been sent, she had been working abroad regularly.

In the summer of 2006 the Independent Living Funds (which provide grants to help severely disabled people to live in the community) told Ms E that her mother's funding had to stop because Mrs N no longer received the highest rate care component. On 19 June Ms E asked the Disability and Carers Service to look again at her mother's award, and they sent Mrs N a form to complete. She noted on the form that she needed help with going to the toilet once a night, five nights a week; and additional help, once a night, five times a week. A decision-maker assessed that Mrs N's help with going to the toilet amounted to prolonged attention and awarded the highest rate care component and the higher rate mobility component from 19 June 2006, but refused to backdate the award as Mrs N had not notified them within one month of the 'change' in her circumstances.

On 4 September 2006 Ms E appealed against the decision not to backdate her mother's award. She said that Mrs N's condition would not go away, that she had always needed help at night and that she (Ms E) would have accepted responsibility for the reduction in her mother's benefit were the Independent Living Funds not asking for £8,845 to be repaid. She enclosed a letter from her mother's GP saying that: *'Over the years Mrs N has gradually deteriorated and has required 24 hour care ... this care has been extended to night time cover, essentially as she is progressively incontinent'*. The Disability and Carers Service told Ms E that they could not review the December 2004 decision because the time limit for appeals had expired.

#### What we investigated

In October 2006 Ms E complained on her mother's behalf to the Ombudsman that the Disability and Carers Service had not taken into account all relevant factors when reducing her disability living allowance. As a consequence, she believed her mother was not receiving her proper entitlement. Moreover, the Independent Living Funds were seeking repayment of a substantial sum of money.

We investigated the way in which the decision was taken to reduce Mrs N's disability living allowance award.

#### What our investigation found

There were significant shortcomings in the way that the decision to reduce Mrs N's disability living allowance was taken. The Disability and Carers Service failed to recognise that the medical report provided by Medical Services was

clearly not fit for purpose: it was not free of medical jargon, and attributed to Mrs N an expression – *'to micturate'* – it seems unlikely she would have used; it was illegible in parts; the doctor had not fully answered all the questions he had been asked; and it included unexplained inconsistencies in the assessment of Mrs N's needs. Despite all this, the report was not referred back to Medical Services for rework as procedures require. As a result the decision-maker had inadequate and incomplete information on which to make a decision, and failed to take all relevant facts into account when doing so.

The decision was made solely in relation to whether Mrs N was in substantial danger at night. But another relevant criterion for night-time needs for the highest rate care component is whether the person needs prolonged or repeated attention in connection with their bodily functions. That was patently relevant to Mrs N's situation (and was the basis of her 1999 award). Her difficulties were the result of a stroke, where the advice available to decision-makers is that someone's condition is unlikely to improve a year after the event. Crucially, the issue of night-time needs for help with bodily functions was clearly stated in Mrs N's application and covered in the medical report. We found no evidence that any consideration was given to these relevant facts.

One of the *Principles of Good Administration* is *'Getting it right'*, which includes an expectation that public bodies should, among other things, follow their own policies and procedural guidance and make proper decisions, giving due weight to all relevant considerations. In this case, the failure to send back the medical report for rework, together with the failure to take into account all relevant facts in coming to the decision, fell so

far short of reasonable expectations that it amounted to maladministration.

*'Putting things right'*, including putting mistakes right quickly and effectively, is another of the Principles. The Disability and Carers Service missed an opportunity to put matters right when Mrs N appealed against the decision not to backdate the new award. Although Mrs N did not specifically ask for the matter to be looked at on the grounds of official error, there are good grounds for officers to have recognised the possibility of such an error and to have addressed it. By that time, Mrs N was considered eligible for the highest rate care component from June 2006 on much the same grounds as in 1999. This, together with the contents of the GP's letter, should have suggested strongly that the December 2004 decision might need reviewing. This, too, was maladministration.

The injustice flowing from the above maladministration was that Ms E suffered worry and uncertainty, while Mrs N was denied a proper consideration of her application.

We concluded the investigation in August 2007 and upheld Ms E's complaint.

## Outcome

At our recommendation the Disability and Carers Service:

- apologised to Ms E and her mother;
- retook the decision of December 2004 in the light of all the relevant facts (they subsequently awarded Mrs N the highest rate care component from 16 March 2005, and paid her arrears of £1,326.40 and £89.79 interest); and
- awarded £100 compensation to Mrs N and £250 to Ms E.

### *Principles of Good Administration*

The following *Principles of Good Administration* were referred to in this case summary:

- *'Getting it right'* (acting in accordance with the public body's policy and guidance – published or internal).
- *'Putting things right'* (putting mistakes right quickly and effectively).

# Complaint about the Learning and Skills Council for England

*Misleading and inaccurate information about education maintenance allowance led to financial loss*

## Background to the complaint

K was due to start a college course on 11 September 2006. In early August her mother, Mrs Q, obtained the necessary forms and guidance notes in order for K to apply for education maintenance allowance (a weekly payment of up to £30 to support people from low income households to continue in learning, administered by the Learning and Skills Council for England – the Council). Mrs Q understood that K needed to open a bank account; realising that that might take time to arrange (K was waiting for a new passport to replace her expired one, and she had no utility or council tax bills in her name), she rang the Council's education maintenance allowance helpline to explain the difficulty and to ask for advice. Mrs Q told us that the helpline said that they could not accept K's application without a valid bank account.

In early September 2006 K and Mrs Q visited several banks and building societies, to enquire about opening a bank account, but each time the lack of proof of identity for K was a problem. Mrs Q rang the helpline several times to explain the problem and was, she said, repeatedly told to persevere. By late September K had started at college and Mrs Q was supporting her financially. According to Mrs Q, she spoke to the helpline on 1 October and was advised to submit the education maintenance allowance application straight away. She was told that although the form would be returned because there were no bank account details, K's application would be registered and backdated on receipt of the bank details. Mrs Q submitted the application form on

2 October, together with a letter describing the difficulties she had faced and the previous day's advice.

K received her new passport and eventually opened a bank account. The Council received the details on 18 October 2006 and backdated her education maintenance allowance to 2 October (where an application is received more than four weeks after the start of the course, payments may be backdated to the date on which the application was received or the start date of the course, whichever is later). When Mrs Q asked the Council about backdating the education maintenance allowance to September, they advised her to appeal. She did so, describing the difficulties she had encountered, and the helpline's contradictory advice. Her appeal was unsuccessful.

Mrs Q approached her MP who wrote to the Minister in January 2007, pointing out that if Mrs Q had submitted the education maintenance allowance application in September without the bank account details, the award would have been backdated to September. But, instead, she had lost money. The MP said that if the Council were prepared to backdate the allowance to the date the form was received, regardless of whether it was complete, applicants should be informed of that from the beginning. If claimants were not informed, then the policy ought to be amended. The Council's Chief Executive replied to the MP, saying that K's payments could not be backdated because there was no evidence to suggest that she intended to apply before 2 October 2006. He did not address the MP's central point.

In February 2007 Mrs Q complained to the Council about the inaccurate information the helpline had given her, and about the refusal to backdate the education maintenance allowance.

In the meantime, the college contacted the Council to say that Mrs Q had asked them for documentation to support her claim that the initial application had been made in September 2006. They said a member of the college staff had spoken to Mrs Q many times dating back to the start of the course, and would be happy to talk to the Council. The Council replied that they would contact the individual if they thought it necessary. In the event, they did not. The Council did not uphold Mrs Q's complaint. They said that as K's application had been received more than four weeks after starting her course, she was only eligible to receive payments from the date of receipt.

#### What we investigated

Mrs Q complained to the Ombudsman in May 2007, commenting that *'In every other aspect of claims for people on low income, emphasis is made on getting in the forms even if you do not have all the information to ensure payments are not lost, but this is not the policy with EMA. I would like to see this changed'*.

We investigated Mrs Q's complaints about being given misleading information concerning when to apply for education maintenance allowance, and about backdating it, which had led to financial loss and inconvenience. (K received no education maintenance allowance for September 2006 and Mrs Q incurred unnecessary out-of-pocket expenses.)

#### What our investigation found

We established that incomplete education maintenance allowance applications are not rejected, but are acknowledged and given a case

reference number. However, the helpline, website and the guidance notes led Mrs Q to believe that K's application would be rejected if submitted without bank account details. She was given inadequate and misleading information, which was maladministrative. The Council's reply to the MP indicated a degree of discretion not provided for in the education maintenance allowance scheme. But, in any event, they made no attempt to examine the evidence offered by the college of K's earlier intent to apply for education maintenance allowance, and so did not give due weight to all relevant factors when considering Mrs Q's complaint. The Council also failed to address the central point of the MP's letter. The Council's maladministration meant that K received no education maintenance allowance during September 2006, which Mrs Q had no choice but to make good, while she had to make a number of telephone calls and write letters unnecessarily.

We concluded our investigation in March 2008 and upheld Mrs Q's complaint.

#### Outcome

At our recommendation, the Council:

- apologised to Mrs Q;
- paid her £100 to remedy the distress and inconvenience caused; and
- paid £120 to K (as the education maintenance allowance applicant) which was equal to the amount she would have received in September 2006.

We recommended that the Council review the backdating rules to ensure they met the scheme's

policy objectives and were flexible enough to permit them to deal with exceptional and unanticipated circumstances fairly and appropriately. The Council said they were satisfied with the flexibility of the scheme rules, but agreed to put in place procedures to create a record of an application that would allow the backdating of payments in appropriate cases.

We recommended that the Council ensure that the education maintenance allowance website, guidance notes and helpline staff explained clearly to applicants that, if they encounter a delay in opening the necessary bank account, they should submit their application form in order to safeguard their entitlement. The Council said that the helpline 'scripts' now include that information.

### *Principles of Good Administration*

The *Principles of Good Administration* were not referred to in our report but this case summary serves to illustrate the following Principles:

- '*Getting it right*' (acting in accordance with published or internal policy and guidance).
- '*Being open and accountable*' (being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete).
- '*Putting things right*' (acknowledging mistakes, apologising, and putting mistakes right quickly and effectively).
- '*Seeking continuous improvement*' (reviewing policies and procedures).



## Complaint about HM Revenue & Customs

*HM Revenue & Customs recovered tax (which had been underpaid as a result of an error on their part) plus interest, failed to pay entitlement to tax credits and failed to address complaints*

### Background to the complaint

Mr P's tax code for 2002-03 included a child tax allowance. In 2003-04 Mr P did not receive a new tax code and his employer used the 2002-03 code (a new code should have been sent, with the allowance removed, due to the introduction of tax credits in April 2003).

In May 2004 HM Revenue & Customs (HMRC) discovered that they had deleted Mr P's previous tax record, so they established a new one and sent a new tax code (with the allowance removed). In December 2004 Mr P completed an online tax self-assessment form for the 2003-04 tax year but was unable to enter his previous tax code (containing the allowance) onto that form, so his self-assessment showed an underpayment of tax for that year. In January 2005 he contacted HMRC.

In February 2005 HMRC sent Mr P a self-assessment statement showing underpaid tax of £499.28. Mr P said that his tax only appeared underpaid because he had been unable to insert the correct code on the self-assessment form. In March 2005 Mr P claimed tax credits (his claim was backdated to December 2004).

In April 2005 HMRC told Mr P that he should have received a different code for 2003-04, had underpaid tax and that tax credits had replaced the child tax allowance. Mr P asked HMRC to liaise with the Tax Credit Office (to whom he copied his letter) in order to offset his unclaimed

tax credits against the underpaid tax. In May 2005 HMRC said that he should pay the underpaid tax.

### Complaint to HM Revenue & Customs

In May 2005 Mr P sent a formal complaint letter to HMRC and wrote to the Tax Credit Office asking if he was eligible for tax credits from April 2003. In June 2005 HMRC said that a new tax code should have been issued for 2003-04, offered to recover the underpaid tax by adjusting Mr P's 2005-06 tax code and told him to contact the Tax Credit Office as he appeared to be entitled to claim from April 2003.

Correspondence continued and in October 2005 Mr P escalated his complaint to HMRC's Area Director; he asked for the underpaid tax and unclaimed tax credits issues to be resolved and to be paid compensation for inconvenience. HMRC said they would investigate.

In December 2005 HMRC wrote to Mr P, apologised and offered a compensatory payment of £80. They said that the underpaid tax did not meet the criteria for remittance, that they could not offset against tax credits, that the Tax Credit Office had strict rules about when payments started and that the issuing of the new tax code in May 2004 should have alerted him to the fact that he was no longer receiving the child tax allowance.

In January 2006 the Tax Credit Office wrote to Mr P and said that claims could only be backdated by three months and that income tax liability and tax credit eligibility were separate and could not be offset. In February Mr P paid his outstanding tax bill with interest of £536.48.

## What we investigated

In October 2006 Mr P's MP referred his complaint to the Ombudsman, namely that: HMRC's actions had caused him to suffer financial loss. We investigated Mr P's complaints that:

- HMRC recovered tax plus interest from him which had been underpaid as a result of an error on their part;
- he had not been given his full entitlement to tax credit dating back to 2003; and
- HMRC had failed to fully address his complaints.

## What our investigation found

HMRC acted maladministratively by deleting Mr P's tax code, which caused him actual financial loss. The deletion of Mr P's tax records meant that he did not receive a personalised claim form and other information regarding the introduction of tax credits. Had he done so, he would have claimed and received an award from April 2003.

We found that, although HMRC were technically correct to charge Mr P interest on his underpaid tax, their delay in resolving his complaint allowed the interest to accrue for longer than it should have done.

We found that the standard of HMRC's complaint handling was so poor as to amount to maladministration. They failed to give Mr P the right information (for example, exact details of the tax credit backdating limits) and did not properly manage his expectations (for example, by saying that he appeared to be eligible for tax credits from April 2003). They also missed

opportunities to apologise and failed to act in a joined-up manner when the issues he raised covered both income tax and tax credit matters.

We found that Mr P suffered actual financial loss and was caused additional worry and inconvenience as a result of HMRC's maladministration.

Our investigation, which concluded in March 2007, fully upheld Mr P's complaint.

## Outcome

As a result of our recommendations, HMRC apologised and made the following payments:

- £608 (equivalent to Mr P's tax credit entitlement between April 2003 and May 2004);
- £100 (for distress and inconvenience caused by the deletion of Mr P's tax record);
- £100 (for worry and inconvenience caused by delays and poor complaint handling); and
- £40 (in lieu of the interest paid on the underpaid tax).

### *Principles of Good Administration*

The *Principles of Good Administration* were not referred to in our report but this case summary serves to illustrate the following Principle:

- '*Being customer focused*' (responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers).

# Complaint about the Security Industry Authority

*Licence application and personal details were returned to the wrong person, and poor complaint handling*

## Background to the complaint

On 4 August 2006 the Security Industry Authority (the Authority) wrote to tell Mr S that his application form for a door supervisor's licence was incomplete. They enclosed his payment, identification documents, and the application form of a third party, Mr A. On receipt, Mr S telephoned the Authority to ask where his application form was. The Authority said it appeared that his application had been separated from his documents and replaced with Mr A's application. Mr S asked to speak to someone who would take responsibility for rectifying the problem, but was told that no one could tell him where his application was. Enquiries would be made with the document handling centre. The Authority told Mr S that someone would call him, but that he should call them if he had heard nothing within two and a half weeks.

During August and September 2006 Mr S chased the Authority for progress. On 20 September he asked the Authority for the contact details of someone who could resolve matters or tell him what was going on. He sent a letter of complaint to the Home Office. On 2 October a Customer Services Manager (the Manager) telephoned Mr S. He said it was likely that the two application forms had been switched and that he was having difficulty contacting Mr A. Later in the month, the Home Office wrote to Mr S; they passed on the Authority's apologies for their poor service and outlined the Authority's complaints process.

By the Authority's account, they twice telephoned Mr A in November 2006; he

confirmed that he had received another person's application form. He agreed to return it. Not having received the form back, the Authority wrote to Mr A on 28 November asking him to return it. Also on 28 November a Customer Services Officer (the Officer) wrote to Mr S, apologising for the Authority's error, and saying that they had located his form and were in the process of retrieving it. In a letter dated 12 December the Officer told Mr S that they were having difficulty retrieving the form. During a telephone conversation with Mr S on 14 December, the Manager summarised the letter of 12 December (which Mr S had not yet received), and said it seemed that the letters of 28 November and 12 December contradicted each other, and that the first letter could have been unintentionally misleading. The Manager said he could not guarantee that Mr S's application would be retrieved and advised him to submit a new one. He recognised the trouble caused to Mr S and that he had lost faith in the system.

On 29 December 2006 Mr S replied to the Officer's letter of 12 December. He said that he was not satisfied with the explanation given, and commented that the Authority seemed more concerned that he submit a new application than they were about the original mistake. Mr S said he had little confidence in the Authority's ability to protect his personal data but that, in spite of this, he was enclosing a new application form and appropriate fee.

On 9 February 2007 the Authority wrote to Mr S to apologise for the inconvenience caused. They said they had been dealing with more applications than their system had been designed for, and '*some isolated errors have occurred*'. The Authority refunded Mr S's £190 application fee. On 16 February the Authority wrote to Mr A

again, asking him to return the application form. In March Mr S wrote to the Authority; he acknowledged the refund, but said that he could not accept that they took complaints seriously and that he had not been made aware of, or seen, their complaints policy and procedure. He also complained that he had not been kept informed of progress, and that the Authority's letter of 9 February had not addressed all of his concerns. The Authority apologised to Mr S on 22 March for the delay in replying to his letter of 29 December 2006, for the error over his application form, and for not calling him back much sooner. They accepted they had raised his expectations over the retrieval of his application.

#### What we investigated

Mr S complained to the Ombudsman in January 2007 that the Authority had lost his application form containing his personal details, and that he had not received a satisfactory response to his complaints. He expressed great concern about the potential misuse of his personal information and said he had incurred unnecessary costs and worry in pursuing his complaint.

We investigated the Authority's handling of Mr S's licence application and their handling of his subsequent complaint. During our investigation we listened to recordings of telephone conversations between Mr S and the Authority.

#### What our investigation found

Judged against the *Principles of Good Administration*, the Authority did not get it right in this case. They should not have sent Mr S's form to Mr A and vice versa, the most likely

cause of which was human error. The seriousness of the error, at a time when identity theft is much in the media and can have wide-ranging effects on victims, led us to find the Authority were maladministrative.

Having made a mistake, it was incumbent on the Authority to put things right. However, their complaints process did not deliver the outcome Mr S sought, nor reassure him that the Authority were a reliable organisation. Despite being told that someone would contact him within three weeks, Mr S was not contacted again (apart from a short standard email reply) until almost seven weeks later. The lack of contact exacerbated Mr S's frustrations and indicated to him the Authority's disregard of his legitimate concerns. There was no audit trail of evidence to show what action the Authority took to contact Mr A or to resolve Mr S's complaint. That lack of record-keeping was poor administration.

The Authority failed to explain their complaints process to Mr S. The Home Office outlined the process, but the Authority should have done that themselves. Mr S's frustrations could have been lessened had the Authority explained that his complaint was following a defined process. We saw no evidence that the Authority addressed Mr S's comment that he had not been made aware of a complaints policy. Public bodies should provide clear information about how people can complain, but we found no evidence that information about the Authority's complaints process was widely available to the general public or routinely given to complainants. Things improved after October 2006; the Authority sought to address Mr S's complaint and demonstrate ownership of the problem; they kept him updated and the telephone calls were an attempt at good customer service. That said,

the Authority did unintentionally raise Mr S's expectations about the retrieval of his form.

In conclusion, the Authority's initial mistake combined with an ineffectual complaints process amounted to maladministration. They did not get it right, nor did they make a good job of attempting to put things right. They did not, at least initially, acknowledge and apologise for their mistake, or explain what had gone wrong; nor did they act to put things right quickly and effectively. An ineffectual complaints process is not good public administration. Mr S was left feeling understandably concerned that his personal information had been sent to a third party. He was frustrated and outraged. A customer's perception of an organisation is not only shaped by the way that organisation conduct their usual business, but also by how they respond when things go wrong. As Mr S observed to us:

*'This to me is a classic example of why complainants become frustrated with the system(s) and do not bother to pursue issues or complaints ... . My experiences leave me with the continuing view that the SIA is very poorly managed.'*

We upheld Mr S's complaint and concluded our investigation in February 2008.

### Outcome

There was no evidence that the Authority's mistake was caused by a systemic fault, so we made no recommendations in that respect. We did, however, recommend that the Authority:

- apologise to Mr S for not fully explaining their complaints process to him and for not

addressing this point in their response to his letter of March 2007; and

- review their complaints process, and in particular the need to make information about their full complaints process publicly available, that complainants are routinely given the information about their full complaints process, and that they keep a complete audit trail of their actions to resolve complaints.

The Authority implemented our recommendations.

### *Principles of Good Administration*

The following *Principles of Good Administration* were referred to in this case summary:

- 'Getting it right' (acting in accordance with the public body's policy and guidance).
- 'Putting things right' (putting mistakes right quickly and effectively).

### *Principles of Good Complaint Handling*

The *Principles of Good Complaint Handling* were not referred to in our report but this case summary serves to illustrate the following Principle:

- 'Being open and accountable' (publishing clear, accurate and complete information about how to complain, and how and when to take complaints further).

## Complaint about HM Courts Service

*Failure to act on a request to serve a third party debt order on a specific day*

### Background to the complaint

Ms D obtained a county court judgment against a debtor who owed her £3,411.81. In June 2006 she sent the county court an application for a third party debt order together with the £55 fee. She wrote that *'as it appears crucial to time the application carefully, I would want the action planned so that the judgment debtor's account is frozen on 1st of the month when funds are most likely to be available'*. She wrote again on 3 July and reminded the court about the timing of the order. The court made an interim third party debt order on 26 July and posted it that day. It arrived on 28 July. The debtor's bank accounts were frozen, containing just £150.75. The bank retained £55 for dealing with the order (as they are entitled to do), and a final third party debt order was made in October ordering that Ms D be paid the balance of £95.75.

In August 2006 Ms D's father, Mr J, wrote twice to the court to complain that they had not served the order on the date requested. When he received no reply, he wrote to the Court Manager and received a one line response saying that *'the court cannot control the date an account is frozen'*. Mr J then wrote to HM Courts Service (HMCS) complaining about the lack and level of response, adding that the response he had received was at odds with the advice HMCS gave applicants about the need to consider carefully the date on which a third party debt order is made. In reply, HMCS said that the order was sent on the day it was made and that *'the court is not aware of the time it takes to identify the amount left in accounts in the various banks'*.

They said there had been no maladministration, and so no compensation could be offered.

Mr J wrote back in October 2006. He said it was not true that the court could not control when a bank account was frozen: the court could have posted the order a day or two before the requested target date. He added that it appeared the court had no regard for its own advice and had made no attempt to follow Ms D's instruction. In reply, HMCS accepted that the assertion that the court could not control the date an account is frozen was *'somewhat disingenuous'* as it had some control over the day the order is served. They accepted that Ms D's request for service on a particular date had been ignored and that the order had been sent as soon as it was drawn. They offered £55 compensation.

### What we investigated

Mr J complained to the Ombudsman in April 2007 that HMCS had ignored Ms D's instructions about serving the third party debt order, and that she had lost the opportunity of the claim against the debtor being satisfied.

Our investigation looked at HMCS's handling of the third party debt order application, considered the adequacy of their leaflet *Third party debt orders and charging orders* and scrutinised their handling of Mr J's complaint. During the investigation, we spoke with Mr J and made enquiries of HMCS and the bank.

### What our investigation found

HMCS failed to take account of Ms D's request about the date of service of the order. That was maladministrative. We were not convinced by

their argument that sending a letter by post means that the date on which it will arrive is *'entirely in the hands of the Post Office'*. Most first class letters arrive the next working day, and it was therefore unreasonable of HMCS to fail to adopt that (or a similar) strategy. Even if the order had arrived on the second of the month, that would have gone a long way to meeting Ms D's wishes. If HMCS had felt unable to comply with her request, they should have told her. One of the *Principles of Good Administration* is *'Being customer focused'*. This includes the need for public bodies to aim to ensure that customers are clear about their entitlements; about what they can and cannot expect from the public body; and about their own responsibilities. In ignoring Ms D's request HMCS were not customer focused.

*'Being open and accountable'* is another Principle. The information in HMCS's leaflet about third party debt orders fell well short of this; it did not mention that applicants can serve the order themselves, nor did it refer to the question about whether an applicant can ask for the order to be posted on a particular day. The general disclaimer included in the leaflet (that it cannot explain everything about court rules and procedures) was not sufficient to compensate for the lack of information about how a person can seek to ensure a third party debt order is served on a certain date. That was important and should have been covered by the leaflet. Taken together, these failings were serious enough to be maladministrative. A further Principle is *'Putting things right'*. Part of this is operating an effective complaints procedure which investigates complaints thoroughly, quickly and impartially. Mr J wrote five letters of complaint before he received a response which in any way addressed the points he had made. That fell short of the

standard of complaint handling that Mr J was entitled to expect and was maladministrative.

Did Ms D suffer a financial loss as a result of HMCS's maladministration? We found that no regular deposits went into the debtor's accounts at around the beginning of each month, and nothing was deposited between 28 July and 6 August 2006. Furthermore, as an order is not sent to the debtor until seven days after it is sent to the bank, the debtor in Ms D's case would not have known his bank accounts were subject to a court order until on or after 4 August 2006. We had no reason to believe that, even if the order had been served as Ms D had requested, she would have obtained any more satisfaction from the order than she did. Ms D did, however, suffer outrage and distress. From the inadequate information in the HMCS leaflet and the fact that they did not otherwise explain her options to her, she was also unable to make a fully informed decision about which route to pursue in trying to serve the order on the date she wanted. Mr J also suffered outrage and inconvenience because of the way his complaint was handled.

We partly upheld Mr J's complaint and concluded our investigation in March 2008.

### Outcome

At our recommendation, HMCS paid compensation of £150 (instead of £55) to Ms D and apologised for the outrage and distress they had caused her and Mr J.

We also recommended that the next time HMCS reprint their leaflet, they amend it to reflect the fact that applicants for third party debt orders may choose to serve those orders themselves, and that it states clearly what steps HMCS can

and cannot take to meet requests for service on a particular day or time of the month. HMCS agreed to review the information given to court users on this subject.

### *Principles of Good Administration*

The following *Principles of Good Administration* were referred to in this case summary:

- *'Being customer focused'* (informing customers what they can expect and what the public body expects of them).
- *'Being open and accountable'* (being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete).
- *'Putting things right'* (operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld).

### *Principles of Good Complaint Handling*

The *Principles of Good Complaint Handling* were not referred to in our report but this case summary serves to illustrate the following Principles:

- *'Being customer focused'* (dealing with complainants promptly and sensitively, bearing in mind their individual circumstances).
- *'Putting things right'* (providing prompt, appropriate and proportionate remedies).



# Complaint about Jobcentre Plus of the Department for Work and Pensions

*Failure to appreciate the full scope of the injustice caused by maladministration*

## Background to the complaint

Mr H had been working in Spain for many years until ill health forced him to give up his job and return to the UK in January 2005. In November Mr H was signed off by his doctor until March 2006. Jobcentre Plus advised him to claim disability living allowance (which he did on 11 November 2005) and income support (which he did on 5 December). Following his income support application, Jobcentre Plus told Mr H that as he was aged 61 he should claim pension credit instead. Mr H said that he then claimed pension credit twice during January 2006 and that his applications were lost in the system. He completed another application in March and was awarded pension credit, backdated to 5 December 2005. According to Mr H, he had to increase his bank overdraft because of the delay and incurred charges. (Bank statements for the period between December 2005 and March 2006 show charges totalling £123.52 in the form of interest on amounts overdrawn.)

Mr H's financial problems and ill health were further exacerbated when his son was killed while abroad in February 2006. Mr H had to pay funeral costs of more than £4,000, and was awarded a social fund funeral payment of £989 by Jobcentre Plus. Mr H appealed, as he felt he should have been awarded the full costs of the funeral. Jobcentre Plus then realised that they should not have made a funeral payment: the funeral took place outside the UK and neither Mr H nor his late son met the other entitlement criteria.

In the meantime, Mr H's disability living allowance application had been refused in January 2006.

Jobcentre Plus advised him to claim incapacity benefit; that claim was also refused as he had not paid enough National Insurance contributions in the two years prior to his application. Mr H appealed, on the grounds that he had been paying contributions into the Spanish system. Mr H telephoned Jobcentre Plus in March to discuss the refusal of his incapacity benefit application, and agreed to send them details of his earnings in Spain. Jobcentre Plus received this information from Mr H in April and forwarded it to the International Pension Centre. They, in turn, requested further information from Mr H, which he supplied to his local job centre on 12 May.

## Initial referral to the Ombudsman

In August 2006 Mr H referred his complaint to the Ombudsman. We declined to investigate at that time as he had not been through Jobcentre Plus's complaints procedure. We referred his complaint to the Chief Executive of Jobcentre Plus, giving her an opportunity to resolve the issues. In December the Chief Operating Officer responded to Mr H's complaint. He apologised for the poor advice Jobcentre Plus had given Mr H about income support and pension credit, confirmed that Mr H had since been paid pension credit arrears, and apologised for losing Mr H's initial pension credit application. The Chief Operating Officer explained why the incapacity benefit claim had been refused and provided an update on the progress of this in relation to Mr H's overseas contributions. He also apologised that the information that Mr H had provided in May 2006 had not been forwarded to the International Pension Centre until November 2006. He also provided an explanation for Mr H's funeral payment award and confirmed that he would not be asked to repay it, as it was due to an official error.

## What we investigated

Mr H felt that the response from Jobcentre Plus did not resolve his complaint and he asked the Ombudsman to look again at his grievances. We decided to investigate his complaint in July 2007.

We investigated Mr H's complaint that Jobcentre Plus's response to him of December 2006 was inadequate; that they were maladministrative in failing to compensate him for the bank charges and other expenses incurred as a result of the delay in paying him pension credit because of their misdirection (the costs of telephone calls and travel expenses to Jobcentre Plus and to his MP's office to resolve his difficulties); and that the £50 compensation payment they had made to him was inadequate. Mr H said that he suffered inconvenience, financial loss, and wanted compensation for the charges and expenses he had incurred, and recognition of the stress he and his wife were under as a result of Jobcentre Plus's maladministration.

## What our investigation found

Jobcentre Plus's response to Mr H of December 2006 gave a good explanation for the issues he had raised, and they accepted that their failings had led to some of the problems he had encountered. The clarity of their explanation and acceptance of responsibility was very much in line with the *Principles of Good Administration* ('Putting things right'). However, part of putting things right is also to provide a remedy which fairly reflects the harm someone has suffered. It is here that Jobcentre Plus fell down.

Mr H raised the question of overdraft charges in his complaint. Jobcentre Plus considered this matter as part of their compensation decision,

but then made no reference to it in their letter to him. This omission amounted to maladministration. Had Jobcentre Plus acted in accordance with the Principle of '*Being open and accountable*', this would not have happened. As for the decision not to compensate Mr H for his bank charges, his bank account was already overdrawn before he applied for benefit and the charges were calculated in the form of interest on the amount by which he was overdrawn. Although Jobcentre Plus reasonably concluded that the timely payment of pension credit would not have stopped him becoming overdrawn, they did not consider whether timely payments would have reduced the charges applied to his bank account. It is reasonable to conclude that without the maladministration the charges would have been lower; Jobcentre Plus's failure to consider that point was maladministration. We found that the other costs that Mr H wanted Jobcentre Plus to reimburse (telephone and travel costs) were not brought to their attention until after they made the compensation decision. They could not, therefore, have included these costs in their consideration.

Jobcentre Plus did not take Mr H's individual circumstances sufficiently into account when deciding to pay him compensation of £50. He was suffering both from ill health and bereavement during the very time when Jobcentre Plus made mistakes and delayed dealing with his claims. Mr H had also made clear to Jobcentre Plus that he was under financial pressures, made worse by the late payment of pension credit. There is no evidence that Jobcentre Plus took these significant and relevant circumstances into account, and so fell short of meeting the reasonable expectations as set out in the *Principles of Good Administration* ('*Being customer focused*' and '*Acting fairly and proportionately*'). That was maladministrative.

In summary, Jobcentre Plus's flawed compensation decision meant that Mr H did not receive a remedy which properly recognised the harm done to him as a result of their maladministration. We regarded £50 as insufficient to recognise the worry, inconvenience and trouble that Mr H was put to at a very difficult time. Furthermore, Jobcentre Plus's maladministration in considering the remedy meant that Mr H was put to unnecessary time and trouble in bringing his complaint back to the Ombudsman.

We partly upheld Mr H's complaint and concluded our investigation in March 2008.

#### Outcome

At our recommendation, Jobcentre Plus apologised to Mr H and paid him:

- £200 in recognition of the worry, inconvenience, time and trouble he was put to;
- £20 to cover his bank charges;
- £70 towards his telephone costs; and
- £20 towards his petrol charges.

#### *Principles of Good Administration*

The following *Principles of Good Administration* were referred to in this case summary:

- *'Putting things right'* (acknowledging mistakes and apologising where appropriate; operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld).
- *'Being customer focused'* (dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances).
- *'Being open and accountable'* (stating criteria for decision making and giving reasons for decisions).
- *'Acting fairly and proportionately'* (ensuring decisions and actions are proportionate, appropriate and fair).

# Complaint about the Criminal Records Bureau

*The Criminal Records Bureau provided the complainant's employer with an inaccurate disclosure which wrongly attributed criminal convictions to him*

## Background to the complaint

Mr L required a disclosure (a criminal records check) in order to take up employment in the security industry. He applied to the Criminal Records Bureau (the Bureau) for a disclosure in May 2006 through his employer. The Bureau checked Mr L's details against the police national computer, and identified an individual with the same name and place of birth, and whose date of birth differed from Mr L's only by one year. They therefore issued a disclosure for Mr L – which was sent to his employer – showing that individual's convictions.

Solicitors acting for Mr L promptly wrote to the Bureau, saying that Mr L was clearly not the individual whose details were recorded on the police national computer, and that Mr L denied any involvement in the convictions shown on the disclosure. They asked for a fresh disclosure. The Bureau asked Mr L to complete a dispute resolution form, and to return it along with photographs of himself, which he did. In late June 2006 they sent Mr L's completed form and a photograph to the police, and asked them to investigate Mr L's claim that he was not the individual whose details were on the police national computer.

In August 2006 Mr L telephoned the Bureau. He said that, having arranged with the police to have his fingerprints taken for comparison with the police national computer, he had duly attended his local police station only to find that they were unaware of such arrangements. The Bureau asked

the police to arrange a new appointment, which they did. A comparison of Mr L's fingerprints with those held by the police subsequently established that he was not the individual whose details were held on the police national computer. Having received that information from the police in September, the Bureau sent Mr L's employer a new disclosure on 29 September.

In October 2006 the solicitors wrote to the Bureau seeking compensation for the distress that they said the issue of an incorrect disclosure had caused to Mr L. The Bureau replied saying that the details shown on the police national computer had sufficiently closely matched Mr L's own details, so that it had been reasonable to link him to that record. Furthermore, the other individual lived close to Mr L. The Bureau concluded that they had not acted maladministratively in issuing the disclosure as they did, and so there was no basis on which they might be expected to compensate Mr L.

## What we investigated

Mr L complained to the Ombudsman in January 2007 that the Bureau's actions had led to inconvenience and distress. We investigated whether the Bureau had mishandled his application for a disclosure.

## What our investigation found

The enquiries we made of the Bureau, following receipt of Mr L's complaint, prompted them to reconsider their handling of his case. In their subsequent response, the Bureau said that it had been apparent from the initial police national computer search that the fingerprints of the individual whose convictions had been linked to

Mr L were held by the police. They said they should, therefore, have arranged to have those fingerprints compared to Mr L's fingerprints before issuing a disclosure. The Bureau said that if they had done so, Mr L's employer would have been told from the outset that Mr L had no criminal convictions.

We upheld Mr L's complaint and concluded our investigation in May 2007.

#### Outcome

As a result of our investigation the Bureau apologised to Mr L for the inconvenience that their oversight had caused him and paid him compensation of £550.

#### *Principles for Remedy*

The *Principles for Remedy* were not referred to in our report but this case summary serves to illustrate the following Principles:

- 'Acting fairly and proportionately' (offering a remedy that is fair and proportionate).
- 'Putting things right' (paying compensation where it is not possible to return a complainant to the position he or she would have been in but for maladministration).



# Complaint about the Health and Safety Executive

*Remedy for a mishandled investigation into a serious accident and inadequate preparation for legal proceedings*

## Background to the complaint

In August 2002 Mr F (then a boy) was knocked over by a truck reversing over a public footpath into a yard owned by Company P. He sustained life-threatening injuries, for which he continues to undergo surgery. The Health and Safety Executive (HSE) began an investigation. They obtained the physical evidence from the scene of the accident, gathered by the police, interviewed Mr F and eye witnesses, and took statements from employees of Company P, including the driver of the truck.

In June 2004 Company P were interviewed under caution in accordance with the Police and Criminal Evidence Act 1984. Before that interview, HSE said that they were not considering proceedings against any individual officer or servant of the company. However, the officer assigned to the case told Mr F's family in April 2005 that Company P would be taken to court. HSE told the family that the case would be heard in court in November 2006.

Having heard no more, Miss B (Mr F's sister) contacted HSE on 8 November 2006 but could get no further information. The next day she was told the case was not going ahead and that this had been decided at a case conference (in October 2006), on the basis of Counsel's opinion that the evidence gathered did not pass the evidential test for prosecution. Mr F's family complained to HSE.

The Head of Field Operations for the London area met the family and their solicitor in December 2006. He wrote to Mr F's parents with the results of a review he had conducted. He said that HSE's conduct of the investigation and subsequent legal proceedings had been unacceptable, as had the failure to liaise properly with the family throughout the course of the investigation and subsequent aborted legal proceedings. He apologised unreservedly, and said he would work to ensure that this could not happen again. The Head of Field Operations added that he had thoroughly explored the possibility of reopening the investigation to gather more evidence, but there was little chance of gathering evidence which might support a successful prosecution.

## What we investigated

In January 2007 Miss B complained to the Ombudsman that HSE's apology was not sufficient redress for their inadequate investigation and their preparation for subsequent legal proceedings. She sought compensation for the distress that HSE had caused her family. She wanted the compensation to reflect the effect of the maladministration on any future damages Mr F might receive, and reassurance that no other family would have to go through what they had suffered.

The focus of our investigation was whether the actions HSE had taken to remedy the injustice to Mr F and his family were adequate in the circumstances.

## What our investigation found

Our investigation established that Miss B's complaint to HSE had prompted them to take a number of steps in an attempt to remedy her complaint, and to reduce the chances of their faults and failings being repeated. Action included:

- an apology;
- developing proposals to make the best use of enforcement to deliver health and safety priorities, and to improve the efficiency and effectiveness of investigation and prosecution activities;
- sharing the key learning points from Mr F's case;
- ensuring HSE keep interested parties properly informed throughout the course of investigations and subsequent legal proceedings;
- introducing a system to ensure that investigation reviews are carried out and recorded. Existing documents were revised to give more details about what reviews should include and what should be recorded, and to allow lines of enquiry and decisions to be recorded in a way which should ensure the review meets its objectives;
- ensuring that HSE do not decide to prosecute without evidence to support a successful prosecution, and that all reasonable lines of enquiry are properly considered;
- introduction of an improvement programme focusing on investigations and enforcement to raise competence levels; and
- introducing a new computer system with modules to help track the progress of investigations and the submission of prosecution reports and their approval, and to ensure that legal proceedings are properly managed.

Mr F and his family had a reasonable expectation that HSE's investigation into his serious accident would be thorough and competent, and determine whether or not health and safety legislation had been breached (and that HSE would pursue a prosecution effectively if it had). HSE failed them on every count.

Although HSE had taken steps to minimise the chances of a recurrence of these failings, we upheld Miss B's complaint that the individual remedy offered by HSE to Mr F was inadequate. Our investigation was concluded in October 2007.

## Outcome

We recommended that HSE pay compensation to Mr F.

The Chief Executive replied, saying that HSE regretted that they had added to the already great level of suffering in this case, and asking that his personal regret be conveyed to Mr F and his family for the mistakes made. He offered compensation of £2,000. We regarded that to be an appropriate amount.

We did not share Miss B's view that redress should take into account any effect HSE's maladministration would have on any future damages (that would have involved considerable speculation as to the outcome of any prosecution of, or civil claim against, Company P).

## *Principles for Remedy*

The *Principles for Remedy* were not referred to in our report but this case summary serves to illustrate the following Principles:

- '*Getting it right*' (considering all relevant factors when deciding the appropriate remedy, ensuring fairness for the complainant).
- '*Putting things right*' (considering fully and seriously all forms of remedy, such as an apology, explanation, remedial action or financial compensation).
- '*Seeking continuous improvement*' (using the lessons learnt to ensure the maladministration is not repeated, and using complaints to improve services).



# Complaint about the Department of Health

*Failure to ensure that accurate information about copyright was provided on a website*

## Background to the complaint

In 2003 a charity (the charity), whose aim is to provide accurate information and advice to drug users, made use of some photographic material that they found on a website sponsored by the Department of Health (the Department). On the website, it was stated that all material was Crown copyright unless otherwise stated and that Crown copyright material could be used without charge for health promotion purposes. There was no indication that the photographs were not Crown copyright. The charity used some of those photographs on their own website.

The charity were later approached by a photographer who claimed copyright of the photographs, asked for payment of £5,098.83 and subsequently issued court proceedings.

The charity approached both the Department and the Central Office of Information. The charity were referred to copyright information on the website and were told that this was a matter between them and the photographer, and it was suggested that they might wish to seek legal advice. The charity subsequently paid the fee, settling out of court with the photographer.

## Complaint to the Department

In October 2006 the charity made a formal complaint to the Department, which replied in November and said that, although they accepted that the charity had mistakenly believed the images they used were Crown copyright, they could not take responsibility for that. They also

referred to the copyright statement on the website from which the images had been taken.

The charity made a further complaint, asserting that nothing on the website had indicated that the images they had used were not Crown copyright and that some of the copyright information had been added more recently.

In January 2007 the Department replied and said that the website use statement had been on the site since October 2003 (except for a period in February to March 2006 when it had been inadvertently removed). They maintained that they had no legal liability and that it had been the charity's responsibility to contact the website to establish the copyright status of the images. The Department apologised for 'gaps' in their communications with the charity during 2006. The charity wrote again to the Department, restating their position and subsequently asked for a meeting to discuss the issue. The Department said that they had provided all of the information they could and told the charity that they could make a complaint to the Ombudsman.

## What we investigated

In March 2007 the charity's complaint was referred to the Ombudsman. We investigated the charity's complaint that the Department failed to ensure that accurate information about copyright was provided on a website that they sponsored. The charity said that, as a result, they had incurred costs of £5,098.83.

The purpose of our investigation was not to determine whether the Department had any legal liability in this matter but to decide whether they had been maladministrative. As part of our

investigation we obtained an archived 2003 version of the website from which the charity had taken the images for use on their own website.

### What our investigation found

We found that the 2003 version of the website said that material was Crown copyright unless otherwise indicated and that such material could be reproduced free of charge. None of the photographs were labelled or captioned to indicate that they were not Crown copyright. In contrast, the current version of the website does carry warnings that no material should be used without prior approval and indications of the copyright owner of all photographs.

We found that the charity had carefully checked the copyright position on the website. If the website had properly reflected the position and thus alerted them to the fact that the photographs were not Crown copyright, they would have checked further and obtained the relevant permissions or decided not to use the photographs.

We found that the Department had been maladministrative by providing incorrect and misleading information about copyright. This had caused the charity to incur the photographer's fees of £5,098.83 for use of his copyrighted material.

Our investigation, which concluded in December 2007, upheld the charity's complaint.

### Outcome

As a result of our recommendations the Department apologised to the charity and refunded an amount equivalent to the photographer's fees.

#### *Principles for Remedy*

The *Principles for Remedy* were not referred to in our report but this case summary serves to illustrate the following Principle:

- '*Putting things right*' (offering a remedy that returns the complainant to the position that they would have been in were it not for the maladministration).

# Complaint about Jobcentre Plus of the Department for Work and Pensions

*Mishandling of income support payments and inadequate consideration given to appropriate remedy*

## Background to the complaint

Mr K's income support payments were paid directly into his bank account. On 11 February 2006 he wrote to ask Jobcentre Plus to pay him by cheque instead. He instructed his bank to close his account and destroyed his bank card. Jobcentre Plus did not receive Mr K's letter until 14 February, by which time they had already paid his income support payment for 13 February into his bank account, which he could not then access. On receipt of Mr K's letter, Jobcentre Plus suspended his payments, awaiting contact from him to find out if he was going to open a new bank or post office account. On 13 February Mr K wrote to his MP asking what was happening with his payments. He was referred to his local councillor as the reason for changing the payment method related to his council tax. Mr K wrote again to the MP. She contacted Jobcentre Plus which immediately lifted the suspension and hand-delivered a cheque to Mr K for his income support arrears.

Jobcentre Plus apologised to Mr K for what had happened and said that compensation would be considered. The compensation referral included a letter from Mr K to his MP, in which he described the effects of being without income support: no electricity and hence no heat (in sub-zero temperatures), light or hot water; and he could not afford food. He also pointed to his history of heart attacks. Jobcentre Plus decided not to award Mr K compensation; they accepted that their maladministration had interrupted his benefit payments, but felt that the level of inconvenience did not merit compensation.

Jobcentre Plus's file was noted: *'This decision takes into account the observation that the matter could have been resolved at the first point of contact from the customer following the benefit interruption. Benefit entitlement would have been due on 20/02/06. I would have considered it reasonable for the customer to contact the department directly to establish [sic] position with his benefit entitlement as opposed to writing directly to his MP over a week later'*. (At interview, Mr K explained to us that he had approached his MP rather than Jobcentre Plus, because on previous occasions Jobcentre Plus had ignored his letters until the MP had intervened on his behalf.)

## What we investigated

Mr K complained to the Ombudsman in September 2006 that Jobcentre Plus had left him without payment for three weeks, leaving him with no heating, hot water, food and only cold water to drink. He also complained about Jobcentre Plus's refusal to compensate him. At interview, Mr K told us that Jobcentre Plus's actions had meant he could not properly take his heart medicine which had to be taken with food; he had used candles for light; and he had lost touch with his brothers because he would not open his door to them at the time because of his shame at his poverty. He told us that Jobcentre Plus did not ask him how their actions had impacted on him before making the compensation decision.

Our investigation focused on Jobcentre Plus's handling of Mr K's request to change his payment method, and their consideration of a compensation payment.

## What our investigation found

Jobcentre Plus should not have suspended Mr K's payments. Instead, they should have changed the payment method first to ensure his payments would be made by cheque and if they wished to establish his intentions about future payments they should have asked him. Their decision to stop paying benefit into Mr K's bank account but not to start paying it by cheque was maladministration.

Jobcentre Plus were not at fault in making the 13 February 2006 payment directly into Mr K's bank account, as they had not by then received his letter of 11 February.

In general we expect bodies to be given the opportunity to put things right as soon as possible. In this case we accepted it was reasonable for Mr K to have asked his MP for help (rather than contact Jobcentre Plus) because of his history of needing her intervention. It was disappointing that Jobcentre Plus did not ask Mr K why he chose to approach his MP for help, or to ask him how their maladministration had affected him.

We partly upheld Mr K's complaint and concluded our investigation in September 2007.

## Outcome

As a result of our recommendations, Jobcentre Plus:

- reconsidered their compensation decision (examining carefully the situation Mr K found himself in), and awarded him compensation of £400 in recognition of the distress and inconvenience he suffered; and
- apologised to Mr K for not offering him an appropriate payment earlier.

Jobcentre Plus also gave an undertaking that a named officer would ensure a prompt response to any future correspondence from Mr K. They said they would send a holding reply to any future correspondence within five days and a full response within ten days, in line with their normal service standards.

### *Principles for Remedy*

The *Principles for Remedy* were not referred to in our report but this case summary serves to illustrate the following Principles:

- '*Getting it right*' (considering all the relevant factors when deciding the appropriate remedy).
- '*Acting fairly and proportionately*' (offering a remedy that is fair and proportionate to the complainant's hardship or injustice).

PHSO-0003 December 08

Printed in the UK by The Stationery Office Limited  
on behalf of the Controller of Her Majesty's Stationery Office  
ID5987510 12/08

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**Please note**

The telephone numbers of the Parliamentary and Health Service Ombudsman changed on 15 March 2009.

The new contact details are:

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