Parliamentary and Health Service Ombudsman

Report of a review into the Parliamentary and Health Service Ombudsman's handling of Mr Nic Hart's case from August 2014 to December 2017

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Section A: Introduction and background

1. About the Parliamentary and Health Service Ombudsman

1.1. The Parliamentary and Health Service Ombudsman (PHSO) makes final decisions on complaints that have not been resolved by the NHS in England and UK government departments, and some other UK public organisations. It does this independently and impartially. PHSO is an independent national ombudsman service. It is not part of government, the NHS in England, or a regulator. It is neither a consumer champion nor an advocacy service.

1.2. PHSO's vision is to be an exemplary public services ombudsman by providing an independent, impartial and fair complaints resolution service, whilst using its casework to help raise standards and improve public services.

1.3. PHSO looks into complaints where an individual or group believes there has been injustice or hardship because an organisation has not acted properly or fairly, or has provided a poor service and not put things right.

1.4. When PHSO first receives a complaint, it will make initial checks to see if it can deal with the complaint. PHSO may also work with a complainant and the organisation they are complaining about to see if it can help resolve the complaint without carrying out a formal investigation.

1.5. If PHSO's initial checks suggest that it can deal with a complaint, a comprehensive assessment will take place to decide whether it can investigate.

1.6. If PHSO decides to investigate a complaint, it will gather information from the complainant and the organisation they are complaining about before making a final decision about the complaint. When PHSO upholds a complaint, it can recommend what the organisation should do to put things right.

2. About this report

2.1. This report sets out the findings of a review carried out by PHSO into its approach to handling a complaint that it received from Mr Nic Hart (the complainant) in August 2014 and how it pursued its subsequent investigation up to the publication of a report on its findings in December 2017. The purpose of the review was to identify:

   a. The failings in PHSO's approach to handling Mr Hart's complaint

   b. How PHSO would handle a similar complaint if it were made today.

2.2. This report makes clear there were a number of failings in PHSO's handling of Mr Hart's complaint. PHSO has previously told Parliament that there were lessons to be learned from its handling of this case.[1] PHSO has also apologised

[1] Ignoring the Alarms: How NHS eating disorder services are failing patients

to the complainant, personally, in writing and through its investigation report that the investigation took much longer than it should have. In these apologies, it acknowledged and accepted the difficulties and stress this caused the complainant and his family, which PHSO deeply regrets.

2.3. This report has been shared with Mr Hart as well as the committee of MPs that holds PHSO to account on behalf of Parliament, the Public Administration and Constitutional Affairs Committee. It has also been published on PHSO's website.

3. Background

3.1. In August 2014, PHSO received a complaint from Nic Hart about failings in the care and treatment of Averil Hart, his 19-year-old daughter, who had used several NHS services in the weeks leading up to her death in December 2012. PHSO's investigation of Mr Hart's complaint found significant failings in clinical care and/or complaint handling by each organisation named in the complaint.[2] PHSO closed Mr Hart's complaint in December 2017.

3.2. Following publication of the report, Mr Hart sought information about PHSO's investigation through several Subject Access Requests and Freedom of Information requests, prior to a meeting with PHSO to discuss its complaint handling.

3.3. In a meeting in July 2019, PHSO set out its intention to conduct a review into the handling of Mr Hart's complaint, along with identified failings which would be published. PHSO agreed with Mr Hart that this should be completed promptly and committed to doing this within three months. Work on the review commenced in mid-August 2019, with publication planned for mid-November. The General Election on 12 December 2019 delayed publication of this report until after this election.

3.4. PHSO wanted to discuss the review with Mr Hart before proceeding and listen to his concerns about the failings in PHSO's handling of his complaint. The earliest Mr Hart was able to meet with PHSO was in July 2019. However, by carrying out the review at this time, it has enabled PHSO to show the changes it has made to its organisation and the way it carries out casework, to demonstrate learning and improvement since it closed Mr Hart's complaint in December 2017.

3.5. The review has found a number of failings in PHSO's handling of Mr Hart's complaint. These failings caused unnecessary distress to Mr Hart and his family during an already difficult period following the death of a loved one.

3.6. The review has been carried out for PHSO to learn from its failings and to account for that learning publicly. This report is also intended to evidence how the matters that led to these failings have been addressed.

[2] The organisations are Cambridgeshire and Peterborough NHS Foundation Trust, UEA Medical Centre, Norfolk and Norwich University Hospitals NHS Foundation Trust, Cambridge University Hospitals NHS Foundation Trust, and North Norfolk Clinical Commissioning Group and NHS England.

3.7. The review has not looked at the substance of the decisions and judgements made in PHSO's investigation of Mr Hart's complaint. These decisions and judgements were made following an impartial and thorough examination of a substantial amount[3] of evidence gathered from Mr Hart and the people and organisations involved in Averil's care.

4. How we carried out the review

4.1. The review was led by a manager in PHSO's senior leadership team. This manager was not employed by PHSO at any point during PHSO's handling of Mr Hart's complaint. They have no management responsibility for any member of staff who was involved in handling Mr Hart's complaint.

4.2. The review has:

- Identified failings in PHSO's approach to handling Mr Hart's complaint
- Identified changes that have been made, or are currently being made, to improve PHSO's approach to complaint-handling since Mr Hart's complaint was closed in December 2017
- Identified any gaps where further changes to PHSO's approach to handling complaints should be considered.

4.3. The review has looked at the period of time from when PHSO received Mr Hart's complaint in August 2014 to when his case was closed in December 2017.

4.4. To inform the review, we have:

- Listened to the experiences of the following people who were involved in PHSO's handling of the complaint and offered them the opportunity to provide further information: Mr Hart, his advocate, two caseworkers and an external investigator
- Reviewed documents and correspondence related to the case
- Reviewed PHSO's past and current policy, guidance and standards for caseworkers about how to handle complaints
- Reviewed information and data about how well PHSO handles complaints.

4.5. Appendix A sets out in full the scope and purpose of the review of PHSO's handling of Mr Hart's complaint.

[3] The case file includes many hundreds of items of evidence.

Section B: Findings and next steps

5. Summary of findings

5.1. **This review has found a number of failings by PHSO in its handling of Mr Hart's complaint between August 2014 and December 2017. It has also found that PHSO has made improvements, or is in the process of making improvements, as a result of learning from each of the failings that have been identified.**

5.2. PHSO's failings in the handling of Mr Hart's complaint include:

- *Time taken to close the case:*
  Whilst this was a high risk and complex case, it should not have taken as long as three years and four months to conclude. PHSO would expect to close a similar case today in approximately half of this time.

- *Resourcing of the case:*
  There was not a clear and consistent plan in place to resource the investigation. The casework manager requested that a second caseworker was allocated to the case given its complexity, but this was turned down. As a result, there was insufficient resource to effectively manage the investigation, resulting in significant delays.

- *Communication with the complainant*:
  Five caseworkers worked on the case at different times. These personnel changes meant that Mr Hart had to frequently build new relationships and re-tell his story. It was also unclear whether caseworkers or senior managers were Mr Hart's main point of contact. Moreover, former senior managers made financial and other commitments that were not kept, and in one aspect should not have been made. This made it hard for Mr Hart to build and maintain trust in PHSO.

- *Appointment of an external investigator:*
  An external investigator was appointed to work on Mr Hart's complaint in April 2016. Their role and responsibilities were not clearly communicated to Mr Hart or the caseworkers. This led to confusion for all those involved in the investigation. With agreement from former senior managers, the external investigator offered to share their personal contact details to help re-build trust with Mr Hart. This was not in line with PHSO's formal information security policy at the time and meant that PHSO was unable to ensure that information was stored or shared securely.

- *Decision-making:*
  Several different former senior managers directed caseworkers to change their approach in how they carried out the investigation into Mr Hart's complaint. This happened a number of times and resulted in Mr

Hart receiving mixed and sometimes contradictory messages about what PHSO was doing and why, making it hard for him to have faith in the quality and consistency of PHSO's investigation.

- *Use of evidence:*
  PHSO failed to clearly explain to Mr Hart how his evidence had been used or to assure him that it had been given equal weighting in the investigation. A large amount of clinical advice was sought, but there were inconsistencies in the way this was requested and provided, and there was not a robust process in place when different clinical advisers provided contradictory advice.

5.3. The review has found that PHSO has taken steps to learn from each of these failings of its handling of Mr Hart's complaint. From the way complaints are allocated to caseworkers, to the way caseworkers request and use advice from clinicians, PHSO has either strengthened its approach or is currently carrying out work to strengthen its approach to handling complaints.

6. Length of time to close the case

6.1. It took three years and four months to close Mr Hart's complaint. The timeline is as follows:

- In August 2014, PHSO received Mr Hart's complaint.
- After carrying out initial checks to determine whether and how to take forward the complaint, PHSO decided to investigate the complaint. The investigation started in December 2014.
- Over the following six months, draft investigation reports were written about three different organisations named in Mr Hart's complaint. These were issued between February and June 2015.
- In November 2015, Mr Hart asked for a meeting with former senior managers. These took place three times between December 2015 and February 2016.
- An external investigator was appointed to work on the case in April 2016. Conversations took place between Mr Hart and the external investigator to discuss aspects of the report.
- In June 2016, a new investigation report incorporating all six organisations was shared with Mr Hart and the six organisations named in their complaint.
- Over the next twelve months, caseworkers revised the draft report drawing on comments and evidence from both Mr Hart and the organisations complained about.
- In June 2017 and October 2017, further versions of the draft reports were issued and shared with Mr Hart and the organisations named in their complaint. These responded to comments received from Mr Hart and the organisations.

- The final investigation report was issued in December 2017 and the case was closed.

6.2. Each complaint PHSO handles is different. Some complex cases will take a long time to investigate and report on. In Mr Hart’s case, there were several reasons why it took so long to complete the investigation and issue the final report.

6.3. Initially, former senior managers asked caseworkers to produce a separate investigation report for each of the six organisations named in the complaint. At a later date, these managers took a different approach and asked for a single investigation report covering all the organisations named in the complaint. Some of the findings were challenged by Mr Hart and re-drafted to better reflect evidence they provided and to include relevant standards and guidance to support the findings. This resulted in delays to the dissemination of draft and final reports.

6.4. During the investigation, some caseworkers and senior managers left PHSO and other members of staff took over responsibility for the complaint. It took time for new caseworkers and senior managers to get up to speed on the case. These issues are set out in more detail elsewhere in this report.

6.5. Three years and four months was still much too long to complete this investigation notwithstanding its complexity. **This was a failing in PHSO’s handling of the complaint.**

6.6. Since Mr Hart’s case was concluded in December 2017, there have been significant changes to the way PHSO handles complaints. PHSO’s procedures and working practices now focus on case progression, ensuring that undue time is not spent with inactivity on a case. Managers in PHSO’s casework teams receive a daily update on the progress and age of every case handled by their team. This approach allows managers to identify cases that are not making appropriate progress and make sure they are being worked on in a timely way. Other processes have been introduced to monitor and manage case progression during all stages of complaint handling including long-term resource planning and forecasting and regular weekly performance meetings with senior management.

6.7. PHSO measures how long it takes to close all the complaints it receives. It also sets targets to help make sure that caseworkers provide a timely service. Since April 2019, PHSO has closed 52.5% of cases within 13 weeks, 79.5% within 26 weeks, and 92.4% within 52 weeks (correct as of 3 December 2019).

6.8. Some of the complaints PHSO looks at are more complex than others. These may involve a serious injustice, such as avoidable death or harm, or involve several organisations. These cases can fall within the percentage of cases outside of the 52-week target. Looking only at complaints that are complex, in 2018/19 PHSO closed these cases in an average of 681 calendar days (equivalent to 22 months and 12 days). This is 17 months less than the time it took to close Mr Hart’s complaint.

6.9. PHSO has also made changes to resolve cases at an earlier stage. The Ombudsman or his deputy have regular oversight of all high-risk cases and

hold caseworkers to account to ensure that these cases are progressed in a timely manner.

7. Allocating people to work on the case

Assigning caseworkers

7.1. Shortly after PHSO received Mr Hart's complaint, a manager in the casework team identified that because of its complexity more than one caseworker should work on it. This is because the complaint covered many different issues and several organisations. There was a very large volume of evidence to collect and review. This was supported by a risk assessment which concluded that it was a 'high-risk' case.

7.2. The manager's request for an additional caseworker was turned down. As a result, the case was not allocated enough resource. **This was a failing in PHSO's handling of the complaint.**

7.3. Caseworkers and managers repeatedly highlighted to former senior managers that more resource was needed to investigate the complaint. These requests were turned down as senior managers said there was not a significant amount of further work to be completed. The case was briefly re-allocated to three caseworkers who drafted reports on three of the organisations in early 2015. In September 2015, a second caseworker was appointed to the case to replace the original caseworker who had left PHSO.

7.4. PHSO now considers the resource a complaint needs when it first arrives and again when caseworkers carry out their initial checks. This helps to make sure that each complaint is allocated to a caseworker with the appropriate skills and knowledge. Straightforward complaints are allocated to caseworkers who have successfully completed professional caseworker training. Cases that are more complex are allocated to senior caseworkers who have undergone further training. Moreover, PHSO will allocate additional resources to high risk cases when required.

7.5. Cases are allocated taking full account of current caseloads held, the skill level of the caseworker and their ability to progress the case within a reasonable timescale. The caseworkers usually work on several cases at one time (currently around seven to eleven cases on average on complex cases). This allows caseworkers to make progress on some cases while they are waiting to receive evidence or comments on other cases.

7.6. Managers use data to actively manage the flow of cases to caseworkers in real time. This provides flexibility to vary caseloads and allocate these to caseworkers who have available capacity. Managers supervise caseworkers to make sure they are allocated only the number of cases that they can confidently manage simultaneously. In complex cases, caseworkers can seek support from senior managers, including the Ombudsman or his deputy, although the caseworker is still responsible for coordinating work on the complaint and communicating with the complainant.

7.7. PHSO has developed a training and accreditation framework to ensure that caseworkers are equipped with the skills and knowledge to deliver an effective service. On joining PHSO, all caseworkers complete seven days of role ready training to support them in their new role. This is followed by three days of professional skills training. All staff attend training on equality, diversity and inclusion. In addition, caseworkers receive more specialist training, including on vicarious trauma and unconscious bias. All senior caseworkers have completed or are working towards an Advanced Certificate in Professional Practice for Ombudsman Casework. This is a competency-based accreditation programme equivalent to a Level 4 or 5 qualification.

7.8. PHSO has taken a number of steps to ensure that its entire business is now focused on producing high-quality casework. This has included updating internal policy and guidance and introducing Quality Standards and Measures which are designed to help drive continuous improvement of PHSO's casework. These measures examine how well important aspects of casework such as communication with the complainant, use of evidence and clinical advice, decision-making and report writing are carried out. PHSO also collects and responds to regular feedback from complainants on standards set out in its Service Charter. Moreover, PHSO holds a regular casework discussion forum where caseworkers can seek support and advice from senior managers, the Ombudsman and other caseworkers on issues arising from the complaints they are handling.

Handovers between caseworkers

7.9. PHSO investigated Mr Hart's complaint during a period of significant transition, including the organisation's main office relocating to Manchester to help meet the requirement to reduce the annual budget by 24%. This meant that there was a significant turnover of staff as many chose not to relocate to Manchester and a significant recruitment and training programme for new staff was required.

7.10. Five different caseworkers and seven managers were involved in investigating Mr Hart's complaint as individual members of staff left PHSO at different points in time. This resulted in multiple handovers each time a caseworker left PHSO. Information was sometimes lost because handovers were not always handled effectively.

7.11. These personnel changes also meant that Mr Hart had to start from scratch in building a relationship with each new caseworker and telling his story again multiple times at what was an already difficult time for him and his family. This made it harder for Mr Hart to build and maintain trust in PHSO and the people working on his complaint. **This was a failing in PHSO's handling of the complaint.**

7.12. Since PHSO concluded Mr Hart's case, it has introduced a new way of handling complaints. This means that once a complaint is allocated to a caseworker, it is normally overseen by that same caseworker throughout the process until the case is closed. The exception being where the case is escalated to a more senior caseworker following a risk assessment.

7.13. It is impossible to guarantee that caseworkers will never leave PHSO mid-way through an investigation. Whilst this cannot always be prevented, staff turnover at PHSO, including caseworkers, is currently running at 3.3%, well below the civil service average of 9%. PHSO's guidance for caseworkers and their managers now sets out a specific process for managing handovers between caseworkers. This guidance says that caseworkers and their managers must do everything they can to reduce the need for handovers in the first instance – for instance by prioritising work to conclude cases before a caseworker leaves the organisation, wherever this is possible. The guidance also says that caseworkers must produce written handover instructions on all the cases they are handling before they leave PHSO, so information is not lost and other caseworkers can take over cases more easily.

7.14. PHSO has recently introduced a new Casework Management System using MS Dynamics 365 to replace an outdated system. This provides an integrated platform for caseworkers to view and record information on cases. The handover process is being strengthened through having a single, easy-to-access record on each case, which will also support collaborative working between caseworkers and managers.

Appointing an external investigator

7.15. In April 2016, a former senior manager at PHSO appointed an external investigator to work on Mr Hart's complaint. However, their role and responsibilities were not communicated effectively to Mr Hart or to the caseworkers who were already working on the case. This led to a degree of confusion as well as difficulties in building trust between those involved in investigating the complaint. **This was a failing in PHSO's handling of the complaint.**

7.16. This issue was exacerbated when senior managers who had been involved in appointing the external investigator left PHSO during the change programme. There was at times a breakdown in communication that meant the external investigator was not always sufficiently informed about decisions made by the other former senior managers (who then took on responsibility for overseeing the case) about the approach to the investigation.

7.17. PHSO has, however, recently appointed an expert advisory panel (EAP) to provide independent support and challenge to its work. Panel members were appointed following an open and competitive recruitment process with a clear role description. In appointing expert advisors and commissioning them to carry out work, PHSO has drawn on learning from the appointment of the external investigator in Mr Hart's case.

7.18. Members of the expert advisory panel may be asked to carry out a range of activities including providing support and scrutiny to offer an additional level of assurance. Currently, there is no intention that EAP members will act as external investigators. Instead, they may provide expert advice and challenge to the ombudsman. PHSO has developed a process for commissioning EAP members to carry out work. This process is in part based on lessons learnt from failings in its handling of Mr Hart's complaint. For instance, PHSO will

set out in writing what the role of the panel member(s) will be in supporting an investigation.

8. Communicating with the complainant

Quality and consistency of communication with the complainant

8.1. In November 2014, Mr Hart asked his caseworker for weekly updates on the progress of his case. The first caseworker provided regular updates in line with this request. However, as time went on and other caseworkers started working on the complaint, communication with Mr Hart became less frequent and less consistent. **This was a failing in PHSO's handling of the complaint.**

8.2. Several meetings were arranged for Mr Hart to meet with senior managers to discuss the case. These took place during 2016 and 2017. This led to a lack of clarity about who was responsible, caseworkers or senior managers, for communicating with Mr Hart. It also meant that Mr Hart was sometimes told different things by different people, making it hard for him to trust in the quality and consistency of PHSO's investigation. **This was a further failing in PHSO's handling of the complaint.**

8.3. For example, during a meeting with Mr Hart in February 2016, a former senior manager informed him that the investigation would find in favour of all the failings they had identified in his complaint. This was not an appropriate commitment to make as the investigation was not yet complete and the former senior manager was not closely involved in reviewing and weighing-up the many hundreds of pieces of evidence that were collected during the investigation. In the end, although PHSO found there were failings by every organisation involved in Averil Hart's care, PHSO did not uphold every part of Mr Hart's complaint.

8.4. The commitment given was not consistent with PHSO's role as an impartial ombudsman service. Impartiality is essential if members of the public, complainants and organisations PHSO investigates are to have faith in PHSO. While it is right for members of PHSO staff to be empathetic, this must not impact upon their judgement or ability to look at each case impartially.

8.5. PHSO has since taken steps to support and challenge all staff members to achieve the right balance between being empathic and acting impartially during the complaint handling process. Caseworkers are trained in how to step back from a case and look at it impartially. Impartiality is set out as a value that everyone working at PHSO is expected to demonstrate in their work and their behaviour. This was introduced in late 2017 in line with PHSO's new corporate strategy. The impartiality of caseworkers is measured throughout the casework process as well as through mid-year reviews and appraisals. PHSO has also commissioned expert support to assist in ensuring that reports produced also evidence an empathetic approach. PHSO has separately asked an independent research agency to ascertain the views of complainants and organisations as to their perception of PHSO's impartiality. This work is ongoing.

8.6. At the same meeting in February 2016, former senior managers also offered to refund Mr Hart and his team for the transport costs of attending this meeting and other meetings with them at PHSO up to the point of this meeting. Whilst PHSO can offer to pay travel expenses for a complainant who comes to meet with them, it was an unusual and unprecedented offer to use public funds to pay for members of Mr Hart's team to attend these meetings.

8.7. PHSO has since made an exceptional payment to Mr Hart for the cost of his own and his team's travel to meetings with PHSO over the course of the investigation to honour the commitment that was made by former senior managers in February 2016.

8.8. Since Mr Hart's complaint was concluded, PHSO has changed its policies and guidance for caseworkers about how to communicate with complainants. Caseworkers now discuss with complainants at the outset how and how frequently they would like to be updated, within reasonable bounds. This is set out in PHSO's Service Charter, which explains what complainants can expect from PHSO when they make a complaint. The caseworker will ask the complainant about their preferred method of communication (phone, letter, e-mail etc.) and together they will agree the frequency of communication. The caseworker also updates the complainant at specific milestones (e.g. when confirming the investigation, requesting evidence, or setting out their early thinking, or 'provisional view', about an investigation).

8.9. Once a complaint is allocated to a caseworker, this caseworker remains the single point of contact for the complainant throughout the lifetime of the case. This remains the case even in situations where the Ombudsman or his deputy become involved in decision-making. This approach makes sure that complainants have to build a relationship with only one person, and that one person will keep them updated consistently.

8.10. As part of PHSO's professional skills training for caseworkers, all caseworkers are now trained to communicate effectively with complainants. This area of complaint handling is measured so caseworkers and managers can understand how well they are communicating with complainants and whether any improvement is required.

Recommendations for financial remedy

8.11. When PHSO upholds a complaint, it can make recommendations to the organisation complained about to put things right for the complainant.[4] In deciding what recommendations to make, PHSO aims to put the person affected back into the position they would have been in had the organisation's poor practice or behaviour not had a negative impact on them. If this is not possible, for example where the injustice was distress or unnecessary pain that cannot be taken away, PHSO may recommend that an organisation makes a financial payment to the complainant. This is called 'financial remedy'.

[4] Section 7 (3) of the Parliamentary Commissioner Act 1967 and Section 11 (4) of the Health Service Commissioners Act 1993

8.12. PHSO recommended that the organisations named in Mr Hart's complaint should pay financial remedies as compensation for the failings identified that led to Averil's avoidable death.

8.13. PHSO also informed Mr Hart that it would recommend that one of the organisations investigated should make a compensatory payment for poor complaint handling. However, this recommendation was not included in the final investigation report in December 2017. This was because PHSO understood that a cheque for this financial remedy had already been issued by this organisation in 2015, at the time it wrote its first draft report about the organisation. In July 2019, Mr Hart reminded PHSO that he had returned the cheque at that time so the payment had never been made. This mistake has since been rectified and the organisation re-issued the cheque in September 2019.

8.14. In February 2016, during the meeting with former senior managers, Mr Hart was told that PHSO's investigation report would include an additional recommendation for financial remedy to be made by the organisations named in the complaint. This was to reimburse Mr Hart for the costs that the small team supporting him had incurred during the complaints process, such as compiling and correcting information and liaising with PHSO and other organisations. This conversation was never followed up with any discussion about how such costs would be determined. Nor was this understanding ever discussed with the organisations concerned. Former senior managers should not have approached the question of financial remedy in this way. **This was a failing in PHSO's handling of the complaint.**

8.15. PHSO's service is free to use. Free advice and advocacy is available to complainants through NHS advocacy and support services. As a result, complainants are not expected to employ people or pay for privately-funded advocacy services. As such, it is not PHSO's policy to cover any costs, other than travel costs by exceptional prior agreement, that complainants choose to incur during the complaints process.

8.16. Because of the commitment made and not followed through to ask the organisations to meet costs, PHSO has since offered to make a significant exceptional payment to Mr Hart. This payment is not intended to reflect actual costs. At the time of writing, Mr Hart has not accepted this payment.

8.17. Since 2017, PHSO has strengthened the way it decides what financial remedy to recommend. As well as looking at the level of financial remedy recommended for similar cases, caseworkers also follow specific published guidance and policy, known as the Severity of Injustice Scale, which was introduced in June 2018, to help them make decisions about financial remedy. Caseworkers are also expected to consider any money that has already been recommended or paid out by other organisations, awarded by courts, or paid following mediation before legal action.

Sharing information safely and securely

8.18. By the time PHSO brought in an external investigator to work on Mr Hart's case, trust had completely broken down between Mr Hart and PHSO. The external investigator appointed by PHSO gave their personal e-mail address

and telephone number to Mr Hart as a way to offer a more personal and responsive service without having to go via PHSO. This approach had been discussed and agreed with a former senior manager at PHSO. Mr Hart made use of the external investigator's offer, contacting them using their personal email address and telephone number.

8.19. The external investigator tried to ensure that all information related to the investigation was copied to and stored securely on PHSO's central case file. However, a small number of emails were not passed on until a later date.

8.20. Although the external investigator offered to share their personal contacts details as a positive step to help Mr Hart rebuild his trust in the investigation, and had the authorisation for former senior managers to do so, it was not in line with PHSO's formal information security policy at the time. This meant that PHSO could not guarantee that information was saved correctly or shared securely. **This was a failing in PHSO's handling of the complaint.**

8.21. PHSO now has much stricter procedures and policies in place to make sure that information is stored securely and shared safely. During the last year, PHSO has updated its policies to provide clearer guidelines to staff on how to record and store information. These policies have also been updated to make sure they comply with the General Data Protection Regulation (GDPR). PHSO's updated policies are accessible to all staff via the intranet and quality assured by an internal team. As part of their induction, all staff complete a GDPR e-learning course and receive training on how to handle information securely.

8.22. In situations where PHSO has asked an external person to work with the organisation, they are asked to complete a questionnaire on information security and data protection that makes sure they are now working in line with internal ICT, security and information governance polices. In addition, Expert Advisory Panel members will be provided with a secure PHSO iPad and e-mail account to ensure that they can securely receive data. This account must be used at all times for PHSO-related work including communication about investigations.

9. Making decisions

Involvement of senior managers

9.1. A number of different former senior managers were directly involved in making decisions about how to handle Mr Hart's complaint. As a result, PHSO's approach to handling the complaint changed several times during the course of the investigation. This meant that Mr Hart received mixed and sometimes contradictory messages about what PHSO was doing and why. **This was a failing in PHSO's handling of the complaint.**

9.2. For example, at the start of the investigation, former senior managers directed caseworkers to draft individual reports on each of the organisations named in Mr Hart's complaint. This was contrary to the way in which caseworkers had proposed to work. Nearly two years later, senior managers directed caseworkers to take an entirely different approach by drafting a

single report on the whole case. This was a substantial change in direction. Caseworkers did at times attempt to challenge the decisions made by former senior managers, without success.

9.3. While there may occasionally be legitimate reasons to change the way an investigation is being carried out, any changes should be made impartially and based on evidence. In Mr Hart's case, the changes in PHSO's approach not only contributed to the length of time it took to complete the investigation, but also made it hard for Mr Hart to have faith in the quality and consistency of PHSO's investigation. **This was a failing in PHSO's handling of the complaint.**

9.4. In contrast, PHSO now communicates with complainants so it is clear from the outset how the caseworker will approach an investigation. Before starting an investigation, a caseworker must set out in writing what they will and will not look at during the investigation as well as how they plan to do this.

9.5. In high risk or complex cases, the investigation plan is agreed at the outset by a senior manager, which can be the Ombudsman or his deputy who will have regular oversight of the investigation. The caseworker coordinates all work and remains the single point of contact for the complainant.

9.6. The culture at PHSO has also changed significantly since Mr Hart's case was investigated. This means that when senior managers or the Ombudsman are involved in an individual case, there are regular discussions with the caseworker to agree a way forward. This helps to make sure that all decisions about individual cases are informed by caseworkers' detailed knowledge of the case.

Explaining how PHSO uses evidence and makes judgements

9.7. As this was a complex case, caseworkers had to collect and review an extremely large volume of information. It took a long time to get all this information from all the organisations involved in the complaint. Mr Hart raised a concern with PHSO that he felt the evidence they had provided to PHSO was not being equally weighted with evidence provided by the organisations complained about.

9.8. The evidence provided by both Mr Hart and the organisations was given equal consideration and draft reports were written drawing on comments from all parties. However, PHSO failed to communicate effectively to Mr Hart how it had used his evidence, or to assure him that it had been given equal weight. This undermined Mr Hart's faith in the impartiality and robustness of PHSO's investigation. **This was a failing in PHSO's handling of the complaint.**

9.9. PHSO has changed the way it involves complainants in the later stages of an investigation by replacing draft reports with provisional views. Caseworkers are required to set out their current thinking on an investigation once they have reviewed all the evidence and then share this 'provisional view' with both the complainant and the organisations complained about at the same time. This gives all parties an equal and contemporaneous opportunity to comment and provide any additional evidence to the caseworker before they make their final judgements and conclude their investigation report.

9.10. PHSO is currently finalising further guidance for caseworkers on assessing the balance of evidence. This will be published on PHSO's website by the end of March 2020 so that members of the public can see how their evidence is considered, weighted and relied upon.

9.11. Work is also underway to improve the consistency and clarity of investigation reports prior to these being routinely published online by March 2021; a commitment made in PHSO's 2018-21 strategy. This work includes new templates, training and technology.

9.12. Since Mr Hart's case was concluded, PHSO has updated its policies and guidance to be more explicit that evidence should be considered equally, whether it is provided by complainants or by organisations complained about. It states:

> *"We should ensure we assess all of the evidence we receive and give it fair and independent consideration. This includes equally considering evidence provided by the complainant and organisation complained about."*

Requesting and using specialist advice from clinicians

9.13. If PHSO investigates a complaint about failings in clinical care, it may ask independent clinicians to provide peer advice about what should have happened. These clinicians may be doctors, nurses, paramedics or other qualified healthcare professionals who have specialist knowledge about the type of clinical care complained about and are able to explain the relevant clinical and professional guidelines and standards. PHSO uses this clinical advice alongside other information to establish what would have been good practice in the situation, and to then consider the extent to which the standard has been met. This is called the 'Ombudsman's Clinical Standard'.

9.14. In Mr Hart's case, PHSO requested an extensive amount of clinical advice over a nearly two-year period from December 2014 to November 2016. This was requested from nine different clinical advisers including GPs, psychologists, psychiatrists and nursing staff. There were inconsistencies in the way that clinical advice was requested by different caseworkers and in the way it was provided. Sometimes different clinical advisers provided contradictory advice. PHSO lacked clear processes about how to deal with contradictory views in an effective and timely manner. **This was a failing in PHSO's handling of the complaint.**

9.15. The delays and contradictions would have made it understandably hard for Mr Hart to have confidence in PHSO's investigation, as he was asked to review different draft reports based on differing clinical opinions during the first two years of the case. The long time it took for PHSO to obtain comprehensive and robust clinical advice also contributed to the length of time it took to conclude the investigation. **This was also a failing in PHSO's handling of the complaint.**

9.16. Since Mr Hart's case was concluded, significant changes have been carried out – or are planned - in the way PHSO requests, uses and explains how it uses clinical advice. In summer 2018, PHSO commissioned an independent review to look at the use of clinical advice in its casework. The review was chaired

by Sir Alex Allan, a former senior civil servant and a non-executive member of PHSO's board. Sir Liam Donaldson, the former Chief Medical Officer for England, was appointed as an Independent Adviser. The review reported in March 2019 and PHSO is currently in the process of making significant changes to respond to the recommendations made.

9.17. PHSO also published a new version of the Ombudsman's Clinical Standard in August 2018. This places a greater focus on understanding whether the clinical care complained about was based on existing clinical guidance or good practice. This might include, for example, NICE guidelines, guidance from medical or nursing royal colleges, or published research. Caseworkers will consider this alongside a range of other material such as clinical records and what the organisation or clinician complained about told us, as well as clinical advice. They will use an impartial assessment of this full range of evidence to understand what should have happened in the situation complained about, and whether the care and treatment complained about fell short of that. PHSO plans to publish case studies on how it is applying the Clinical Standard to allow the organisations it investigates and others to understand how it is used in practice.

9.18. PHSO also now has a clear process for what to do when it receives contradictory clinical advice. If this happens, PHSO's lead clinician (a senior, qualified clinician who oversees the clinical advice process) will help the caseworker to decide on the appropriate steps to take. This could involve, for example, giving clinical advisers sight of each other's advice or asking clinical advisers to review the evidence they based their advice on. Peer review of clinical advice obtained is now in place for all of the more complex cases and, in exceptional circumstances, PHSO will seek evidence from an additional clinical adviser who can offer a fresh perspective. Lead clinicians also review all written advice provided by external clinical advisers to assure its quality and consistency.

9.19. In future, PHSO plans to share clinical advice with complainants prior to drafting the Provisional Views on the case. A pilot is now underway. The purpose of this change is to give complainants an opportunity to see clinical advice and to have a meaningful discussion about its significance with their caseworker. This will be supported by guidance for complainants, which sets out how clinical advice and evidence will be used. This guidance will also set out how they and the organisations complained about can be involved with this process.

9.20. PHSO increasingly involves clinical advisers at an earlier stage. Caseworkers are encouraged to discuss the clinical issues in a case with clinical advisors prior to any written advice being completed. This helps to ensure that both the caseworker and clinical advisers involved in the case have a good understanding of the clinical context and whether any other clinical evidence is required in addition to advice. For the more complex cases, caseworkers, their manager, and a lead clinician will meet early on in the process, together with the relevant clinical adviser where necessary, to discuss what is needed from clinical advice, how it should be sought, and any other issues relating to the case from a clinical perspective. Caseworkers and clinical advisers are also now encouraged to come together to review clinical advice

and to develop a shared understanding about what its impact on the outcome of the case. Finally, clinical advisers will soon have the opportunity to feed back on the quality of requests for advice from caseworkers on a case and conversely, caseworkers will feed back on the quality of the clinical advice they receive. This has already started for internal clinical advisers.

10. Conclusions and next steps

10.1. This review has found that there were substantial failings in PHSO's handling of Mr Hart's complaint. PHSO's actions – and, in some cases, inaction - undermined Mr Hart's trust in the quality and impartiality of its investigation. Communication was fraught with difficulty. Personnel changes meant that Mr Hart often lacked a single point of contact, and there was a lack of clarity about the involvement of senior managers and the external investigator in the case. Moreover, senior managers made commitments to Mr Hart that were not kept and, in some cases, should not have been made.

10.2. The failings combined to result in lengthy delays to the investigation at an extremely difficult and upsetting time for Mr Hart and his family, who were grieving for a loved one. PHSO has already placed on record its sincere apology for the way this investigation was handled. Following this detailed review, PHSO would again like to apologise for the many failings identified and for the distress experienced by the complainant and his family.

10.3. This review has found that since Mr Hart's complaint was concluded, there have been significant improvements in PHSO's approach to handling complaints drawing on lessons learnt from this case. In each area where failings have been identified, PHSO has either made improvements or is in the process of making improvements to help make sure it will not make the same mistakes again. The review did not identify any gaps where further changes to PHSO's approach to handling complaints should be considered.

10.4. Following the conclusion of this review, a member of PHSO's Expert Advisory Panel who had not previously been involved in this case was asked to consider if there was more that PHSO could have done to identify and explain the failings. They also considered if our response to the failings identified was appropriate. Their feedback was that the review has identified a number of very serious failings in a frank, open and honest way and addressed these in a detailed manner. They suggested, however, that PHSO might want to consider introducing a more routine process to learn from its handling of complex cases in future.

10.5. PHSO is committed to continuously improving its service. It is important that the changes it has begun to make will be sustained. PHSO will continue to account publicly for the quality of its service, including by publishing data about its performance, publishing feedback from complainants through the Service Charter, and accounting to Parliament annually through the Public Administration and Constitutional Affairs Committee. PHSO recognises that it is on a journey towards becoming an exemplary ombudsman service and will continue to demonstrate its performance to Parliament, key stakeholders and members of the public.

10.6. This report will be published on PHSO's website. It will also be shared with Mr Hart and with the committee of MPs that hold PHSO to account on behalf of Parliament, the Public Administration and Constitutional Affairs Committee.

Appendix: Scope and purpose of the review

1. Purpose

The purpose of this work is to:

a. Identify the failings in PHSO's approach to handling Mr Hart's complaint including PHSO's methodology (what we did), culture (how we did it) and performance (how well we did it), and

b. Identify how PHSO would handle a similar complaint if it were made today.

2. Scope

We will:

- Identify failings in methodology, culture and/or performance in relation to PHSO's handling of Mr Hart's complaint
- Identify changes that have been made, or are currently being made, to improve PHSO's methodology, culture and performance since Mr Hart's complaint was closed in December 2017
- Identify any gaps where additional changes to PHSO's handling of complaints should be considered
- Look at the period of time from when Mr Hart made his complaint to PHSO (August 2014) to when the case was closed (December 2017).

We will not:

- Re-open Mr Hart's complaint or carry out a further investigation of the issues raised in Mr Hart's complaint
- Review the judgements and conclusions made in PHSO's investigation of Mr Hart's complaint
- Look at the period of time before Mr Hart brought his complaint to PHSO or after the case was closed.

3. Timescales

PHSO started work on the review on 16 August 2019. Once the scoping and planning phase is complete, PHSO aim to complete the review in approximately three months, as follows:

Weeks 1-3	Weeks 4-7	Weeks 8-12	Week 12
Phase 1	Phase 2	Phase 3	Phase 4
Background research & information-gathering	Detailed research & analysis of information gathered	Report-writing	Sharing & publishing the final report

The General Election on 12 December delayed publication of this report until after this election.

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