

Sir Bernard Jenkin MP
Sent by email

9 January 2020



Dear Bernard

I am writing to share with you our report into the handling of Mr Nic Hart's complaint between August 2014 and December 2017. As PACAC members have not yet been confirmed, we are contacting you in your role as immediate past Chair and we will be providing copies of this letter to Committee clerks.

We made a commitment to complete our review promptly within three months. However, we took the decision to delay the completion of the review until the New Year due to publishing restrictions during the pre-election period and to avoid publishing the report close to the anniversary of Averil's birth and death. We feel that it is important to publish the report now without further delay.

We previously highlighted to PACAC that it took too long for us to complete our investigation into Mr Hart's complaint and that there is learning to take from this. Amanda Campbell, our Chief Executive, met Mr Hart on 30 July 2019 to discuss his concerns about certain aspects of our handling of his complaint and subsequent investigation. At this meeting, Amanda Campbell confirmed that PHSO would carry out a review to examine these in detail and share with him the steps we have since taken to improve the quality and consistency of our complex casework.

We are aware that PACAC may wish to examine our handling of Mr Hart's case once the inquest into Averil Hart's death has concluded. We therefore felt it would be beneficial to carry out this review now to assist and inform this aspect of the Committee's future work.

The review has found failings across a range of complaint handling processes including communication, the use of evidence and clinical advice, decision-making and information security. The report addresses the context and circumstances of each failing.

The review also identifies the changes that have taken place to improve our handling of complex cases and to address any remaining gaps in best practice. We have set out in our report how we have addressed each of these issues through improvements to policy and guidance, workforce development, and leadership of the organisation. We recognise that many of these are at an early stage of implementation and will take some time to embed.



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We have recently appointed an Expert Advisory Panel to provide independent support and challenge to our work. We asked James Titcombe, one of our panel members who had no prior involvement in the case, to consider if there was more that PHSO could have done to identify and explain the failings in our handling of Mr Hart's case. James Titcombe's feedback was that we had undertaken a thorough review which had identified a number of failings in a frank, open and honest way. To help ensure the continuous improvement of our service, he suggested that we introduce a routine process to learn from our future handling of complex cases. We have strengthened the report on the back of his feedback. Furthermore, James Titcombe has written a blog about the role he played in the review, which we will be publishing on our website alongside the report.

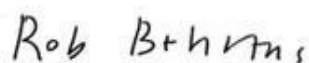
Having found failings in the handling of his case, we have written to Mr Hart to offer a payment of financial remedy for £2,950. The level of payment we have offered is equivalent to the highest level of financial remedy we recommend in cases where we find failings in the way an organisation has handled a complaint. This amount is in addition to an exceptional payment of £10,000, which I offered to Mr Hart in November 2017. This resulted from the fact that we did not follow up on our commitment to recommend that the organisations named in Mr Hart's complaint should make a payment for the costs his team incurred up to the date of our meeting with him on 12 February 2016. To-date, Mr Hart has not accepted this payment and I have restated our offer in my letter to him. In April 2018, Mr Hart was reimbursed for travel expenses of £1,734.73 incurred during the course of our investigation.

In the report we have also re-stated our apology to Mr Hart for the impact of our failings on him and his family on what must have been an extremely challenging time following the death of a loved one.

We are committed to continuously improving our service and the experience of complainants. We will work hard to monitor and sustain the changes set out in our report. We greatly value the scrutiny that PACAC applies to our organisation on behalf of Parliament and the wider public. I look forward to discussing the findings of our review and our future plans with the new Committee in due course.

I plan to share a copy of this report with the new PACAC Chair following any appointment.

Yours sincerely



Rob Behrens CBE
Ombudsman and Chair
Parliamentary and Health Service Ombudsman