Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

# Ending Groundhog Day

## Lessons from Poor Complaint Handling


# Contents



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This report is laid before the National Assembly for Wales under paragraph 14 of Schedule 1 of the Public Services Ombudsman (Wales) Act 2005

# Foreword

This is the second thematic report I have published during the last 12 months. Back in March 2016 I issued a report focusing on out of hours care in Welsh hospitals. In that report I called for an independent systemic review of out of hours care and I am pleased to see that the Welsh Government is progressing with this work. I hope that this and any future thematic reports that I publish will also be used to drive systemic changes.

A considerable proportion of the complaints that land on my desk only come to me because of a failure by public bodies to effectively deal with complaints. The introduction of the role of Improvement Officer in my office in 2015, placing greater emphasis on best practice and corporate cultural development, has led to my office having better engagement with these bodies and I hope ultimately there will be an improvement in complaint handling and learning from complaints.

Whilst the Ombudsman scheme in Wales is well respected at home and abroad, I feel strongly that we must ensure that it is future-proofed and citizen-centred. I believe fresh legislation is required to have a real impact on tackling poor service delivery. Now the Fifth Assembly is in place I will be pushing ahead with making the case for new powers and I hope to see a new Public Services Ombudsman for Wales Act introduced during the next year.

Earlier this year, the Organisation for Economic Co-operation and Development (OECD) released a report stating that in the absence of patient choice in Wales, there must be a "voice" for service users. This office is in the unique position of receiving thousands of expressions of public service user dissatisfaction every year. Making sure these voices are heard is key to driving up standards for the benefit of all.

**Nick Bennett**
**Public Services Ombudsman for Wales**


# Introduction

### The responsibility and role of the Ombudsman

The Public Services Ombudsman for Wales has legal powers to examine complaints about public services. He also investigates complaints that members of local government bodies have broken their authority's code of conduct. He has a team of people who help him to consider and investigate complaints. He is independent of all government bodies and the service that he provides is impartial and free of charge.

The aim of the Ombudsman is to put things right for users of public services and to drive improvement in those services and in standards in public life using the learning from the complaints received.

### Introduction

For a country as small and interconnected as Wales, it is surprising that good practice does not always travel well.

The way we go about our daily lives is underpinned by how public services are run – prompt access to medical treatment when our loved ones need it, safe streets to walk down, our household waste collected regularly and gritted roads when the winter bites.

Public services face some monumental challenges and following a long period of austerity and a rapidly ageing population it is not surprising that sometimes things can go wrong. But rather than accept this as inevitable it is important we learn and ensure mistakes are not repeated.

In too many of the cases that come to this office, service failure is compounded by the respective organisation failing to investigate the original complaint correctly.

When Keith Evans undertook an independent review of complaint handling within NHS Wales in 2014, he did so with a wealth of private sector experience, as a former Chief Executive and Managing Director of Panasonic UK and Ireland.


## Introduction

He talked about effective private companies using complaints "as a gift" as any commercial organisation operating in a competitive market that does not listen to its customers will perish.

Conversely, examples used in this thematic report illustrate that public services can at times put up more of a defensive barrier and a blame culture develops.

It has often been said that the most successful companies treat complaints as "free consultancy". Too often in public services in Wales this does not appear to be the case. Cultural change is needed in public services to ensure they learn from complaints.

This report is focused on the whole of the public sector. It highlights 18 cases where complaint handling has not been acceptable across all sectors of public service in Wales and picks out some key themes that are consistent with other cases we receive each year.

In Wales there are several complaint systems and procedures. Whilst the Welsh Government has introduced a Model Concerns and Complaints Policy, it is not enforceable. The NHS has its own statutory complaints procedure Putting Things Right, while Social Services also operate to statutory requirements and use *A guide to handling complaints and representations by local authority social services*, issued by the Welsh Government.

Securing clear and consistent data collection from these systems is just one issue that needs addressing if public services are to improve performance, but what is more important is a cultural shift away from blame and fear to a positive environment where complaints drive improvement. Only through bold leadership of public services across Wales will we see a positive and lasting impact for service users.

> "Only through bold leadership will we see a lasting impact for service users"


# Analysis

In June 2014 a document entitled "A Review of Concerns (Complaints) Handling in NHS Wales" was published. This was a review established by the Welsh Government into the way NHS Wales handles concerns and complaints; it was led by Keith Evans and was subtitled "Using the Gift of Complaints". Although that report looked at complaint handling in the NHS only, the principles contained within it are equally applicable to other bodies within the Ombudsman's jurisdiction.

Whilst it may be difficult for public bodies to see a complaint as a gift, it is undeniable that complaints can be a rich source of material which can and should be used to improve services. Neither should organisations restrict themselves to learning from their own complaints only. The Ombudsman publishes a quarterly Casebook, containing summaries of reports issued. This provides a useful source of information which can be used to improve services across organisations.

Many of the people who make complaints to the Ombudsman express two main motives – the desire for the failings in their own complaints to be put right, but also, and sometimes even more importantly, the wish to avoid something similar happening to anyone else in the future.

The quality of complaint handling depends on many factors. One of the most important is the culture within an organisation determining the way in which complaints are viewed, and, perhaps stemming from that, whether sufficient resources are dedicated to the task. Resources are an important factor for several reasons. Clearly there must be sufficient numbers of staff dedicated to considering complaints. Members of staff who provide the service (and who were involved in the matters complained about) must have adequate opportunity to respond to a complaint; this means both that they should usually be asked to provide their account, and also that they have sufficient time in their undoubtedly busy schedule to dedicate to the task. Being the subject of a complaint can be very stressful for the members of staff involved, and it is therefore important that they are adequately supported throughout the process, so that they can provide their input truthfully and, if necessary, feel able to critically analyse their own actions. It is essential that staff at all levels within an organisation approach complaints with an open mind, honestly analysing what, if anything, went wrong, and being willing to learn lessons from any failings identified.


## Analysis

Complainants have the right to have their complaints considered objectively, to have a thorough investigation carried out which takes account of all relevant facts, and to have a clear, evidence-based explanation of the conclusions reached. They are also entitled to expect their complaint to be determined in a timely manner, due allowance being made for the complexity of the complaint and the enquiries necessary.

The complaints made to the Ombudsman's office show that complainants do not always receive such a service. Evidence gathered from consideration of complaints shows that complaint handling can go wrong in many different ways, and on many different levels. It is concerning that some of the faults identified are recurring, showing that organisations have not always learned from theirs, and others', previous mistakes. Themes emerging, and exemplified by the case studies in this report, include:

- inappropriate/inadequate involvement of staff complained about
- inadequate investigation of complaints
- delay in responding to complaints
- incomplete/inaccurate responses to complaints
- defensive attitude to complaints.

The case studies in the final section are included to show the wide variety of ways in which complaint handling can go wrong. In some instances the way in which the complaint was handled, and the subsequent outcome, can be described as nothing less than absurd. Whilst these cases do not seem to show a pattern of failings, they do illustrate a certain lack of logical thought in the consideration of some complaints, and lead one to surmise that the organisation was doing little more than "going through the motions". Such an approach does not enable the organisation to learn from its mistakes.

> "In some instances the way in which the complaint was handled can be described as nothing less than absurd."


Analysis

### Inappropriate/inadequate involvement of staff complained about

The stories of **Mr K** and **Mrs T** illustrate opposite ends of the spectrum in the way in which a member of staff, whose actions led to the complaint, was involved in the complaint response. In **Mr K's** case, the complaint response merely reiterated what the Consultant in charge of the patient's care had said. There was little challenge from the Health Board's investigator when the Consultant's account did not reflect what was in the records or respond to all matters raised. The Health Board's response was therefore little more than the Consultant's defence of his actions. In contrast, in **Mrs T's** case, the member of staff concerned was not even told about the complaint, far less asked for their account of events. Both approaches are inappropriate and equally unhelpful: no investigation can be thorough and impartial if it neither seeks to establish facts from the member of staff involved, nor challenges the accounts and actions of those involved.

### Inadequate investigation of complaints

The complaints procedures operated by public bodies do not prescribe exactly how investigations should be carried out. However, all emphasise that complaints should be investigated fairly and thoroughly. Complaints to the Ombudsman have shown that this does not always happen. Included in the case studies is one (**Mr X's story**) relating to the adequacy of an inquiry carried out by a Health Board into the cause of a patient's death. However, if lessons are to be learned, it is important that such an inquiry is comprehensive. It seems illogical that the Senior Investigations Manager who chaired the inquiry was unable to challenge clinical decisions despite believing there were inaccuracies in the inquiry report. Such an approach does not show a willingness to be open about any failings, and certainly does not suggest that lessons would be learned for the future.

> "it is not acceptable for an organisation to take over a year to respond to a complaint"

### Delay in responding to complaints

The timescales prescribed by complaints procedures are generally challenging, allowing for between 20 and 30 working days for a




final response to be provided. This will not always be achievable, particularly in those complaints which raise a range of issues, or involve a large number of staff members. However, it is not acceptable for an organisation to take over a year to respond to a complaint, and then to take a further eight months to respond to questions arising from its response, as happened in **Mr A's** case. Neither is it acceptable for an organisation to apparently ignore several prompts by a complainant for a response, and even then to fail to meet its own promised deadline (**Mrs S's story**). In **Mrs C's** case the organisation had not responded to a complaint 18 months after receiving it, and even, after the Ombudsman's intervention, failed to provide its response within the time agreed with the Ombudsman for doing so.

### Incomplete/inaccurate responses to complaints

In many of the stories included, the organisation's response was incomplete or contained information for which there was no supporting evidence, or, indeed, which was actually contradicted by the documents concerned. For example, the response to **Mr K's** complaint contained a number of inaccuracies, failed to provide a full account of the circumstances and was deemed by the Ombudsman to be misleading. He also considered the response provided to **Mrs A** to be disingenuous, since it was not in accordance with the clinical records.

**Miss B's** story shows how responses to complaints are not always comprehensive. Her complaint raised child protection issues, so it was appropriate for these to be investigated under child protection procedures. However, there was no consideration of the remainder of her complaint. In **Mrs S's** case, despite the time taken to respond to her complaint, the response was inadequate and failed to address both matters about which **Mrs S** had complained.

### Defensive attitude to complaints

**Miss B's** and **Mr X's** stories are both examples of inadequate investigation of complaints, with the organisations' attitude being overly defensive in both cases. In **Mr X's** case the Ombudsman questioned the objectivity of the Health Board's own investigation into **Mr X's** death. In **Miss B's** case, the Council, even in its response to the Ombudsman, maintained its defensive stance regarding its actions when it had become aware of concerning allegations about a foster carer's actions.


# Future considerations

Whilst the case studies highlighted in this report are not typical of complaint handling across the Welsh public sector, they are, sadly, not "one-offs."

There are a number of recurring themes that need to be addressed to ensure service user complaints receive proper consideration and an appropriate response.

**1. End the "fear and blame" culture and avoid defensiveness**

Despite numerous reports outlining cultural weaknesses in public sector complaint handling, it is clear from the Ombudsman's caseload that some cultural issues remain unresolved. Whilst there is no obvious panacea to address this, defensiveness and staff fear of being blamed can mean that the user does not receive a fair, just and timely outcome to their complaint.

Ending a culture of defensiveness, fear and blame and moving towards a commitment to learning, from the top to the bottom of an organisation, will improve this. This requires progressive leadership from senior staff and a commitment to identifying how the failing could have been prevented and how the complaint can be resolved promptly. Positive leadership will also help ensure that complaints are responded to with candour.

Only with cultural transformation will the public sector in Wales move beyond Groundhog Day where poor quality complaint handling is repeated.

**2. Effective Governance**

Boards and cabinets responsible for governance need to ensure that austerity or other pressures are not used as an excuse for poor complaint handling.

They should:

a) ensure that the person investigating a complaint is sufficiently independent of the events complained about, and that the person determining the body's response to a complaint is both sufficiently senior and independent

b) receive reports on complaints within their organisation on a regular basis

c) satisfy themselves that measures have been put in place to ensure the same failings do not happen again, and that lessons from one part of the organisation are learned more widely

d) seek out and learn from external best practice

e) identify and tackle endemic issues.


## Future considerations

**3. Robust Training**

Bodies need to ensure that all staff charged with conducting investigations have received appropriate training so that organisations can be confident that robust investigations are carried out.

Complaint officers need to be supported by senior members of staff such as the Chief Executive, or a Director with responsibility for complaints, to ensure that they receive timely responses to their enquiries from staff complained about/involved in a complaint.

**4. Data Collection**

Currently in Wales "Putting Things Right" sets out the requirements for handling complaints about health services. There is also a Model Concerns and Complaints Policy, issued by the Welsh Government in 2011, for other public service providers. However this has no formal status, and there is no consistent public reporting of complaints information across public services in Wales. Whilst the Ombudsman can draw conclusions from complaints made to him, the more substantial data on complaints made to public bodies is not available. Without this it is difficult to identify patterns of poor complaint handling and to tackle bad practice.

In Scotland, the Scottish Public Services Ombudsman has a Complaints Standards Authority role that ensures guidance given to bodies has statutory force. Under these arrangements there is published information in a consistent form showing how public bodies handle and respond to complaints. This allows comparisons to be made and areas for improvement to be identified.

The draft Public Services Ombudsman (Wales) Bill recommends moving to a similar model in Wales. If this legislation is enacted it will allow the gathering and reporting of consistent and comparable data across public services in Wales.

> "Only with cultural transformation will the public sector in Wales move beyond Groundhog Day"


# Case studies

Staff involvement in investigation

## Mr K's story

### The complaint

Mr K complained that his mother, Mrs K, was inappropriately discharged from hospital with a swollen inflamed leg, indicative of a blood clot. Mrs K was re-admitted to hospital within 24 hours, when a blood clot was identified, but she was discharged again within 24 hours and re-admitted again four days later. Sadly, Mrs K died the following day from septicaemia, kidney failure and deep vein thrombosis.

The Health Board asked the Consultant who had been in charge of Mrs K's care during her first hospital admission for his comments on the complaint.

### The Ombudsman's findings

The Ombudsman found that the Consultant's response, which had informed the Health Board's response to Mr K, was inadequate. Elements of the response were factually inaccurate, and the Consultant failed to mention a number of important matters. The Health Board did not ask other clinicians who had been involved for their input into the complaint response. The Ombudsman concluded that the Health Board's response to Mr K did not provide a full and unambiguous representation of the circumstances of Mrs K's admissions and discharges, and was ultimately misleading and in itself a service failure causing Mr K an injustice.

### The Ombudsman's recommendations

The Ombudsman recommended that the Health Board ensure that in future its complaint responses did not rely solely on input from an individual clinician who had responsibility for the matters complained about.




## Mrs T's Story

### The complaint

Mrs T complained about her care and treatment when, during surgery to remove an enlarged lymph node from her neck, one of her cranial nerves was severed. She said that she had not been fully warned that this was a risk before she consented to the procedure. The Health Board appointed its Head of Nursing for Acute Services to conduct an investigation into Mrs T's complaint.

As part of the investigation, the Ombudsman's Investigator spoke to the Surgical Registrar who had carried out the surgery about the consent process. It was apparent that the Surgical Registrar did not know about Mrs T's complaint to the Health Board, or that made subsequently to the Ombudsman. The Health Board confirmed to the Ombudsman that it had completed its investigation without obtaining comments from the Surgical Registrar, or informing her of the existence of the complaint. It said that the Consultant retains responsibility for patients in his care, and it would expect that the Consultant would discuss any issues of concern with the doctors in his team and provide the complaint response for the corporate concerns team.

### The Ombudsman's findings

Whilst accepting the Health Board's comment that the Consultant retains overall responsibility for a patient, the Ombudsman did not consider this justified its failure to obtain an account of events from the clinician at the centre of the complaint. He found that the Health Board had not properly investigated the complaint, and this therefore called into question the reliability of its conclusions. In addition, it meant that the Surgical Registrar had no opportunity to defend herself against the allegations, or to learn from any identified shortcomings.

### The Ombudsman's recommendations

The Ombudsman asked the Health Board to remind the Concerns Team of the need to ensure that formal responses to complaints are informed by evidence from the treating clinician involved.




## Mrs A's Story

### The complaint

Mrs A complained about the care her mother, Mrs K, received after sustaining a fall while an inpatient in hospital. In particular Mrs A complained about the clinician's decision to only X-ray Mrs K's hip, and not her lower back, following the fall. An X-ray carried out several days later revealed a fracture in her lower vertebra. In its response to the complaint, the Health Board referred in some detail to the Orthopaedic Staff Grade Doctor's examination of Mrs K following her fall, and his subsequent management of her condition.

The Ombudsman noted that the clinical records contained no entries made by the Orthopaedic Staff Grade Doctor and that there were inconsistencies between the Health Board's response, informed by the Orthopaedic Staff Grade Doctor, and what was contained in the clinical records. The Health Board confirmed that the account contained in its response to the complaint was based on a meeting and discussions between the Investigating Officer and the Orthopaedic Staff Grade Doctor, who had confirmed he had made no entries in the clinical records.

### The Ombudsman's findings

The Ombudsman found that critical aspects of the Health Board's complaint response were not in keeping with the clinical records and were therefore disingenuous. He concluded that an investigating officer has a duty to raise evident inconsistencies in clinical records with clinicians, especially when claiming that the nursing and medical records had been reviewed as part of the investigation. He also noted that doctors have a duty to respond fully and honestly to complaints.

> "Critical aspects of the Health Board's complaint response were disingenuous"

### The Ombudsman's recommendations

The Ombudsman recommended that the Health Board consider measures for improving the accuracy of complaint responses.




## Mrs B's Story

**The complaint**

Mrs B complained about a number of issues relating to the management and care of her late husband before his death from invasive bladder cancer. The complaint was received by the Health Board on 17 April, and on 21 May a member of the complaints team wrote to a clinician asking for comments on the complaint. A reminder was sent to the clinician on 21 August but the clinician's response was not provided until 13 November.

**The Ombudsman's findings**

The Ombudsman accepted that the complaints team needed the clinician's comments to enable it to provide a meaningful response to Mrs B's complaint. However, the time taken by the clinician to respond to the complaints team's request (some six months) was unacceptable. Whilst the Ombudsman appreciated that clinicians are busy treating patients, not engaging in the complaints process, and having to be chased for comments, does not enable the Health Board to provide timely responses to complaints.

**The Ombudsman's recommendations**

The Ombudsman recommended that the Health Board remind clinicians of the need to ensure engagement in a timely manner with the complaints process.




## Ms C's Story

**The complaint**

Ms C had complained to the Health Board in June 2014 concerning her son's ophthalmic care, but had not received a response to the complaint. She complained to the Ombudsman in January 2016, asking him to investigate the Health Board's handling of her complaint and secure a response.

**The Ombudsman's findings**

The Ombudsman resolved the complaint as an early resolution on the basis of the Health Board's agreement to a number of actions, including an apology, financial redress for the complaint handling delays, and confirmation as to when the written response would be sent. These actions were to be completed by 15 March 2016.

However, the Health Board failed to implement the recommendations it agreed, and the Ombudsman invoked his powers to issue a special report – the first time the Ombudsman had done so against a Health Board.

The Ombudsman said he had "*...serious concerns about the Health Board's management of its complaint handling function and also, in light of the evidence, its candour and governance.*"

**The Ombudsman's recommendations**

The Ombudsman made a series of recommendations. These included issuing the complaint response to Ms C without further delay, offering further financial redress for the delay, and providing copies of the letters to the Ombudsman. He also recommended that the Chief Executive of the Health Board issue a personal response to the Ombudsman after undertaking a review of the resources within the Concerns Team and its capacity to deal with the number of complaints received in a timely way.

> "The Ombudsman had serious concerns about the Health Board's management of its complaint handling function, candour and governance."




## Mr W's Story

### The complaint

Mr W had made several complaints to a Housing Association about works carried out on his property as part of an improvement project in the area, including damage caused to his property, exposure to harmful contaminants which rendered parts of his property inaccessible and failure to respond to his concerns. The Housing Association had not responded to Mr W's letters, and almost a year later he made a formal complaint to the Ombudsman.

### The Ombudsman's findings

On receipt of Mr W's complaint, it was found that the Housing Association had held several meetings as well as a site visit to try to resolve the issues raised by Mr W, including an asbestos related issue. However the Housing Association had not made Mr W aware of this and had failed to respond to his concerns for almost a year. Therefore, as far as Mr W was aware, the Housing Association had ignored his concerns and the effects these were having on his family and life, which led the Ombudsman to conclude that the Housing Association's failure to comply with its complaints procedure amounted to maladministration.

### The Ombudsman's recommendations

The Housing Association agreed to take various actions to address the shortcomings identified which included to provide Mr W with an apology from the Chief Executive and a redress payment of £500 for the distress and inconvenience caused to him due to the protracted length of time the Housing Association took to respond to his complaint; a review of their complaints policy including the introduction of regular audits of its complaint handling; and training for staff on how to deal with complaints.




## Mrs S's story

### The complaint

Mrs S complained to the Ombudsman that a Council had failed to follow its own procedures and deal properly with a complaint she made about two planning matters. The Council took a protracted length of time to respond to Mrs S's concerns, and many of her requests for updates went unanswered.

### The Ombudsman's findings

In 2011/2012, Mrs S reported alleged breaches of planning control to the Council. In June 2013, Mrs S emailed the Council Director to complain that nothing had been done about the two planning matters she had raised. Her complaint was subsequently passed on to the Council's solicitor. Over the course of the next six months Mrs S sent numerous emails to the solicitor but did not receive a single response. Eventually at the end of March 2014, after contacting the Head of Planning, Regeneration and Commissioning to request an update on her complaint, she received a letter from the Head of Highways Transport and Recycling which stated that the solicitor had been unable to carry out his investigation due to work pressures but that the investigation would now go ahead and a response would be sent by the end of April but again this deadline passed without Mrs S receiving anything. The solicitor finally contacted Mrs S in June 2014, but even then his response was insufficient as it only addressed one of the two complaints Mrs S had made. It was not until September 2014 that the solicitor fully responded to the remaining complaint.

Mrs S waited over 12 months to receive a substantive response to her complaint which the Ombudsman found completely unacceptable. During this time, the Council failed to keep Mrs S up to date with what was happening and her emails to the solicitor were ignored. When they eventually responded to Mrs S they failed to address both planning complaints.

In addition to this, the Council took three months to provide the Ombudsman with information requested relating to the investigation, suggesting that the Council had still not put measures in place to deal with complaints in a timely manner.




### The Ombudsman's recommendations

The Ombudsman asked the Council to apologise to Mrs S for the failings in handling her complaint and pay her a redress amount of £500 for the time taken to pursue her complaint. In addition the Ombudsman recommended that the Council keep Mrs S updated on her second complaint at monthly intervals, and that it ensure that in future it has sufficient resources available to deal with complaints in a timely manner. He noted that long delays in complaint handling simply put more pressure on already overstretched resources.

## Mr A's Story

### The complaint

After attending her GP with a history of diarrhoea in September 2011, Mrs A was treated for diverticulitis[1] in early 2012. A week later she attended A&E reporting suffering from abdominal and chest pain for a year. A CT scan was performed but there was no evidence of any further complications. Several GP visits followed and despite her GP referring her to a Consultant Gynaecologist with suspected ovarian/peritoneal cancer following a blood test, subsequent tests were postponed. In June 2012 Mrs A was finally diagnosed with cancer and underwent months of chemotherapy. Despite her condition improving during the first half of 2013, Mrs A sadly died in the July.

Mrs A had complained to the Health Board in January 2013 that she believed she had been misdiagnosed and that her symptoms were not taken seriously. She also complained that she should have received the blood test earlier and that an ultrasound should have been carried out which would have diagnosed the cancer earlier. The Health Board responded to Mrs A's complaint in March 2014 – eight months after her death – stating that all reasonable investigations had been carried out and that an ultrasound would have been unlikely to have diagnosed the cancer when the CT scan had not. The response also stated that Mrs A would not have benefited from surgery.

Mr A was not satisfied with this response and wrote back asking further questions about Mrs. A's treatment, as well as requesting an explanation as to why the Health Board had taken so long to answer the original complaint. Eight months later the Health Board provided Mr A with a response.

### The Ombudsman's findings

Following clinical advice, the Ombudsman did not uphold the clinical aspects of the complaint. However he did uphold the complaint about the way the Health Board dealt with Mr and Mrs

[1]Bubbles of air in the wall of the bowel that connect with the inside of the bowel.


## Case studies

### Delay

A's concerns. Whilst acknowledging the complaint was complex and required input from a number of clinicians, he found it unacceptable that it had taken 14 months for the Heath Board to provide a response, whilst failing to keep the couple informed of what was happening. In addition Mr A waited a further eight months for a response to his letter querying the Health Board's original reply about Mrs A's care.

**The Ombudsman's recommendations**

The Ombudsman recommended that the Health Board apologise to Mr A for the poor complaint handling, as well as pay Mr A a redress amount of £750 for the time and trouble it had taken to pursue his complaint. The Health Board was also asked to implement a process for updating complainants if a complaint response is delayed, as well as to remind the clinicians who were involved in this case that they must respond promptly when asked to comment on a complaint.




## Mr X's story

### The complaint

Mr X suffered with chronic renal failure and regularly attended his local hospital for dialysis. While on holiday in Tenerife Mr X became seriously ill and was repatriated back to the hospital, where he was not seen by a consultant for over 12 hours. His condition deteriorated rapidly and he sadly died a few hours later.
Following her husband's death Mrs X wrote to the Health Board to complain about his treatment, asking them to review their procedures. Six months later she had still not received a response, as the Health Board was unable to locate Mr X's medical records and so had not commenced its investigation.

Mrs X complained to the Ombudsman that the decision to not treat Mr X immediately in the intensive therapy unit ultimately led to his death. She also complained about the misplacing of Mr X's medical records for six months following his death.

### The Ombudsman's findings

In addition to the number of serious clinical failings in Mr X's care, the Ombudsman's investigation raised several questions about the objectivity of the Health Board's inquiry into his death. The Health Board carried out a Root Cause Analysis (RCA) of Mr X's death which concluded that his death had not been avoidable due to his existing medical conditions. However the Senior Investigations Manager who chaired the RCA was not happy with the conclusions reached, believing there to be several clinical inaccuracies in the report yet was unable to challenge clinical decisions. The Senior Investigations Manager was also unsure if the RCA had been discussed at board level before being signed off.

The Health Board was also heavily criticised for misplacing a letter from the hospital in Tenerife which could have affected the outcome of the RCA, as well as Mr X's medical notes which led to the delay in arranging a meeting with Mrs X to discuss the findings of the RCA. Mrs X waited eight months to receive a response to her complaint to the Health Board, and the Health Board's failure to accept that there were failings in Mr X's care meant that Mrs X was forced to bring her complaint to the Ombudsman, prolonging the distress caused by her husband's death.

The Ombudsman concluded that the Health Board's handling of the complaint was a significant injustice, and their failure to accept the inadequacies in Mr X's care meant Mrs X had to take the time and trouble to complain to him.




**The Ombudsman's recommendations**
The Ombudsman made a number of clinical and governance related recommendations, as well as recommending a payment of £20,000 to Mrs X and her family for the distress caused by the manner of Mr X's death and the need to pursue her complaint further.

## Miss D's story

**The complaint**
Miss D complained to a public body that it had divulged confidential information about her children to a third party against her wishes. Believing her complaint had not been properly investigated by the body, she contacted the Ombudsman.

**The Ombudsman's findings**
The body admitted from the start of the Ombudsman's investigation that it had not acted in accordance with its Complaint Handling Procedure and failed to provide Miss D with a Complaint Response Plan detailing how its investigation would be carried out. Its procedure had been strengthened prior to the Ombudsman's investigation to ensure these plans were routinely sent out. Miss D was particularly vexed that the third party involved was not consulted during the investigation by the body concerned. The body told the Ombudsman that it generally would not undertake third party enquiries when investigating complaints. However this was not clearly stated in its complaints procedure. Even though gathering evidence from the third party might not have changed the outcome of the investigation in any way, it would have at least demonstrated to the complainant that the investigation had been thorough.

**The Ombudsman's recommendations**
The Ombudsman recommended that the body should apologise to Miss D and conduct a review of its Guide to Complaints and Complaint Handling Procedure, making changes to these where necessary. He also suggested informing complainants that third parties will not automatically be consulted as part of a complaint investigation. This might have satisfied Miss D that the investigation was as thorough as it could be and avoided the need for her to take the matter further.




## Miss B's story

### The complaint

Miss B complained that her children, but in particular her son, X, suffered psychological harm in the care of a foster carer. She said that the Council failed to remove them from the foster carer's care when it received an expert's report which she said confirmed this. She also complained about the way in which the Council dealt with her complaint.

### The Ombudsman's findings

The Ombudsman found that the fostering service's social worker, and X's social worker, had not visited the foster carer and X respectively as frequently as required by Regulations. He concluded that the foster carer had not been supported appropriately to manage X's challenging behaviour, and that it was possible that further work with X might have improved his experience in care.

The Ombudsman found it "astonishing" that the Council had taken little action when it received a report from a psychologist, which had been critical of the foster carer's care of X and contained an allegation which, if true, would have amounted to a breach of Regulations. The Ombudsman noted that "the Council seemed more interested in explaining why it considered the psychologist's comments to be "out of order" rather than detailing any action it had taken in the light of them".

The Council was correct to consider the complaint initially under Child Protection procedures. However, there were failings in the way it did so, including a delay in the holding of the required strategy meeting and the failure to invite all prescribed agencies to the meeting. The Council did not undertake a comprehensive consideration of the remainder of the complaint.

### The Ombudsman's recommendations

The Ombudsman made a series of recommendations including an apology from the Council for the failings identified and a payment of £1000 for the benefit of the family in recognition of the distress suffered by Miss B and X.

The Council agreed to take steps to ensure that any allegation against a foster carer is investigated immediately, in accordance with national guidance, and that the Fostering Panel and Care and Social Services Inspectorate Wales are notified of the allegation and the outcome of the investigation.

It also agreed to ensure that foster carers receive effective supervision in accordance with Council policy, and that written records of such supervision are maintained on the carer's file. Finally,




the Council agreed to take steps to ensure that in future it complies with the procedures contained in the All Wales Child Protection Procedures for consideration of allegations against professionals.

## Mr P's story

### The complaint

Mr P complained about the care and treatment provided to his late wife, Mrs P, in January 2014 at a GP surgery, and about the way in which his subsequent complaints had been dealt with by the Health Board.

The Health Board was asked by Mr P's advocate to undertake an investigation of his complaints against the Surgery under "Putting Things Right" provisions, applicable in Wales for complaints concerning the NHS, which it agreed to.

Mr P remained unhappy with the Health Board's subsequent investigation, stating that not all relevant parties were involved in the evidence-gathering process and not all aspects of his complaints were dealt with. He felt the Health Board had not understood or dealt with his complaint properly.

### The Ombudsman's findings

With regards to the complaints handling aspect of the complaint, the Health Board acknowledged shortcomings in how it dealt with the complaint. It said it had reviewed its investigation again, confirming that whilst the Clinical Director had met with a senior partner at the respective surgery, he had not met with two of the doctors involved in Mrs P's care, although both were aware of the investigation.

The Health Board apologised that the investigation had not adhered to the timescales (set down by "Putting Things Right") and that no minute taker had been present when the Clinical Director met with Mr P which, in hindsight, it was felt would have been both appropriate and beneficial.

The Ombudsman agreed that both other doctors should have been interviewed, and had the meeting about Mr P's concerns been properly minuted, the investigation could have ensured all aspects of his complaint were looked into.

### The Ombudsman's recommendations

The Ombudsman recommended that the Health Board should apologise in writing to Mr P for its shortcomings in complaint handling and make an offer of financial redress for the time and trouble he took to pursue his grievance and the additional distress caused as a result.


Case studies

## You couldn't make it up...

**In other cases the Ombudsman found a number of other surprising and concerning failings. These include:**

- The investigating officer's report was not available (and therefore not seen by the person responding to the complaint) when the complaint response was sent to the complainant. The report, when provided, was very brief and did not fully or explicitly address the specific complaints.

- The Health Board's complaint response failed to address the recommendations made by an Independent Review Panel (a stage in the NHS complaints process which has since been removed).

- The Reviewing Officer at stage 2 of the Council's complaints process identified failings on the part of the Council and made a number of significant recommendations. Nevertheless, despite this, he did not uphold the complaint.

- The Health Board's first response to the complaint was poor. At a later meeting held with the complainant, some relevant members of staff were not present, the patient's records were not available and staff were not able to answer some of the questions raised. Despite further correspondence, some of the outstanding issues were not addressed.

- The Health Board's investigation of the complaint (which had been supported by a consultant involved in the early stages of the complainant's care) was carried out by a second consultant who was, at least partly, the subject of the complaint.

- The complaint was about both the Health Board and the Council; the Health Board removed from the final response to the complainant that part of the response which was critical of the actions of the Council, and which had been previously agreed by the Council.

> "The investigation was carried out by the consultant who was the subject of the complaint"


# Appendix 1

## Model Concerns and Complaints Policy

On 29 July 2011 the Welsh Government issued the Model Concerns and Complaints Policy for adoption by Public Services Providers in Wales and associated guidance for implementing the policy. All non-NHS bodies involved in the complaints referred to in this report have adopted the policy and guidance within their organisations; however, there is a statutory social services complaints policy which all councils must operate when considering complaints by users of their social services (see following section).

The model policy has an informal stage, and a formal investigation stage. An organisation should generally respond to a formal complaint within 20 working days; in more complex cases, if it is not possible to do this, the organisation should give a complainant an estimate of how long it will take, and keep the complainant updated during the course of the investigation.

The guidance accompanying the model policy stresses that complaint handling should be complainant-focused, complaints should be investigated fairly and thoroughly ("investigate once, investigate well") and decisions should be evidence-based. Lessons should be learned from complaints to improve service design and delivery.

## Social services complaints procedure

A new statutory procedure was introduced by the Social Services Complaints Procedure (Wales) Regulations 2014 and accompanying guidance for handling social services complaints in 2014. This procedure is broadly similar to the model policy referred to above, in that it has a "local resolution" stage and a formal investigation stage. A formal investigation must be conducted by an Independent Investigator (i.e. a person independent of the authority) and when the complaint is about children's services, must also involve an Independent Person. A formal investigation must be completed within 25 working days of the date on which the details of the complaint are agreed. The report of the Independent Investigator must be considered by the authority, and the Director of Social Services must decide whether to uphold the complaint.

Prior to 2014, the procedure included a third stage for consideration of social services complaints – an Independent Panel hearing. This stage was abolished by the 2014 Regulations.


## Appendix 1

### NHS complaints procedure

The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 came into force in April 2011. They prescribe arrangements for complaint handling in all NHS bodies in Wales, and were supplemented by guidance entitled "Putting Things Right". Complaints must be investigated properly and appropriately and details of complaints should be shared with the staff member involved "where appropriate". A complainant should generally receive a response within 30 working days; if this is not possible, the response should be sent within six months and the complainant kept informed of the delay and the reason for it. Lessons should be learned from complaints, and complainants informed of action which has been taken as a result of the complaint.

The Regulations contain provision for the payment of redress in certain circumstances if the investigation concludes that harm may have been caused to the complainant through the fault of the organisation. Further investigation may be necessary if the initial investigation concludes that this may be the case, and extended timescales apply to the consideration of redress.

# References

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