COMPLAINTS AND REMEDIES PROVIDED BY OMBUDSMEN.

A. Introduction

1. The aim of this seminar is to examine the role of the Ombudsman in oversight and review of decision making by public bodies.

    a. The making of the complaint and remedies sought;

    b. The practice of making an effective complaint and its process;

    c. Perceived problems and reform.

B. Making a complaint the starting points

2. Ombudsman schemes were set up by Central Government primarily to monitor the behaviour of public bodies and to allow members of the public to challenge the administrative decisions of public bodies. The Ombudsman schemes often provided the only means of redress for "maladministration" and the administrative failings of public bodies. In the process of investigation the Ombudsman has a broader remit over factual inquiry than the High Court in Judicial Review proceedings.

3. The Ombudsman's remit, in general, is limited to investigating administrative actions only; not to consider complaints about the merits of decisions or interfere with the public bodies' discretion over particular issues. Therefore, there is a clear distinction between the Ombudsman's remedy for dealing with issues of maladministration and issues of legality (dealt with by the High Court or Upper Tribunal in judicial review claims or in statutory appeals).

4. The key issue with the challenge to any administrative decision making is whether the remedy sought matches the issue to be challenged and whether the remedy sought is **effective**.

5. There are a number of Ombudsman who have jurisdiction over particular public bodies. The two main Ombudsman schemes we are going to be concerned about today are the Parliamentary and Health Service Ombudsman ("PHSO") which deals with all Central Government departments and health bodies, and the Local Government Ombudsman ("LGO") which deals with local authorities.

6. In addition you have numerous other Ombudsmen:

    •the Financial Ombudsman Service;

•the European Ombudsman;

•the Legal Ombudsman;

•the Property Ombudsman, Ombudsman Services: Property and the Property Redress Scheme;

•the Housing Ombudsman;

•the Prisons and Probation Ombudsman;

•the Ombudsman Services: Energy; and

•Telecommunications Ombudsman.

7. The key issue when making a complaint to any Ombudsman is checking whether that particular complaint can be dealt with by that particular Ombudsman. Thus, the first question to ask is: What are the powers of the particular Ombudsman as to the remedy that they can provide. In particular, what are their powers to make recommendations as to injustice arising out of any maladministration, which they might identify. For example, the PHSO (which has the NHS remit) will consider how injustice arising out of “service failure" can also be addressed.

8. As an example the jurisdiction of the PHSO are:

•slow or unsatisfactory responses to letters, and other unnecessary delays;

•incorrect or misleading information and advice given by government officials;

•refusal by government officials to give information to which a person is entitled;

•rudeness, discrimination or unhelpfulness by staff;

•failure to follow reasonable rules in procedures and administration;

•failure to acknowledge mistakes or apologise;

•failures in the quality of service. In the NHS, this could be the care and treatment provided by a doctor, nurse, and dentist or other professional, such as a long wait for treatment or an operation. Within other government departments or agencies, it could be failure to treat people fairly and with dignity.

9. The PHSO cannot usually look into the following types of complaint:

•complaints about consumer issues, including gas, electricity and water;

•problems which can usually be taken to court;

•complaints about the police;

•complaints about government policies;

•complaints about services relating to a non-NHS hospital or nursing home (unless the services are paid for by the NHS);

•complaints about services funded by local authorities such as care homes. The Local Government Ombudsman deals with these complaints.

What is "maladministration"?

10. The issues for the Ombudsman to determine in any complaint, is: Whether there has been "maladministration" leading to "injustice". There is no specific definition of "maladministration" and it simply a catch all term which covers administrative failings of public bodies that the Ombudsman service was set up to investigate. When the Ombudsman scheme first started a list of what comprised maladministration included:

- Bias;
- delay;
- neglect;
- turpitude;
- incompetence;
- perversity;
- arbitrariness.

11. The guidance issued by the PHSO and the LGO give further various examples of maladministration which include: bad decision-making, poor advice, delay and failure to inform someone of their rights.

12. So these are examples of what the Ombudsman was set up to deal with and if you are not sure whether your complaint is about maladministration you can check with the relevant Ombudsman's helpline. The Ombudsman's fundamental job is to look at what the public body has done wrong in terms of maladministration and then consider whether this has caused the complainant injustice. The Ombudsman will, therefore, only make recommendations to put matters right when they are satisfied that the injustice has been caused by the maladministration and when a complaint is made it is necessary to explain what the maladministration was and how it caused injustice.

Injustice

13. "Injustice" is a much broader concept than the concept of "damage" for the purposes of say tort law. Unlike tort remedies, the Ombudsman's remedies are not dependent on establishing the necessary prerequisites in tort law. For example, proof of foreseeability, proximity or legal causation is not required to demonstrate proof of injustice. Consequently, the levels of compensation payments made in tortious claims are not necessarily a useful guide as a monetary or other remedy for redressing maladministration.

14. The concept here is "just satisfaction" and the overarching principle for matching a remedy to injustice is one with common-law roots. So the approach is as far as possible put to complainant back in the position they would have been but for the maladministration having occurred. The ombudsman will occasionally make formal recommendations or "suggestions" for the benefit of others who suffer equivalent injustices even when the maladministration has not been shown to have caused injustice in a specific cases. From 1 April 2008 the LGO was given explicit powers to investigate to this end and although there was no equivalent express power the PHSO has done this in a number of cases involving maladministration in the construction of compensation schemes.

Remedies in general

15. Although Ombudsman's reports have offered very little reasoning for any recommended remedies there is relatively clear and well established guidance on the principles deployed.

16. In December 2009, for example, the LGO published an updated version of guidance on good practice remedies, which was originally issued in 2004. The idea is to promote consistency in remedying financial compensation or other

forms of redress for maladministration. Similarly in February 2009 the PHSO published guidance principles for a remedy which begins:

> ”This document gives our views on the principles that should guide how public bodies provide remedies for injustice or hardship resulting from the maladministration or poor service. It sets out for complainants and bodies within the Parliamentary and health service ombudsman's jurisdiction how we think public body should put things right when they have gone wrong and our approach to recommending remedies.”

17. It is clear that the Ombudsman's recommendations typically take four forms:

    a. The first being an action, or processed based, remedy which recommends that specific step is taken because good administration requires this in the circumstances or that a new necessary decision is taken in a proper and timely manner;

    b. Secondly, direct remedies where it is proposed that the complainant is given award of something which is tangible in recognition of the unjust consequences of the maladministration. This can be directly linked to loss or expense to which the input, or the value of the service that what had been provided;

    c. Thirdly, indirect redress remedies, recommending a payment that acknowledges the effects on the complainant of the maladministration and injustice such as distress and stress; and

    d. Finally, recommendations for systemic change for the benefit of others.

18. These are the basic tangible remedies that arise out of maladministration. The Ombudsman will expect an acknowledgement of responsibility and an apology from the public body in addition.

19. So what kind of injustice can an Ombudsman's recommendation address? The courts of had very little to say on the meaning of injustice.To date, the only indications are that it plainly includes outrage as in R v Parliamentary Commissioner for Administration ex parte Balchin (No2) (2000 paragraph) 79 P &CR 157 and loss of opportunity and it is inherently a far broader concept of damage and does not depend on strict legal principles and causation. Within the LGO guidance is an approach in the Investigators Handbook where it identifies examples of objective injustices such as financial loss, loss of the service,

damage to property or amenity, or loss of opportunity. It also gives examples of subjective losses such as distress, hurt feelings and outrage. So these are the remedies that you can obtain, in theory, from the Ombudsman in respect of the Ombudsman identifying injustice.

Action-based and process-based remedies for injustice

20. The aim of action-based and processed-based remedies is broadly similar to the objective in obtaining mandatory or quashing orders from the High Court. The Ombudsman, however, unlike the High Court cannot compel or direct any action. The status of the decision may, for example, lead to remedial actions which can include a review or amendment of care plans to reflect an individual's needs and explain in details how those needs will be met. Or, for example, the decision may have the effect of requiring a Local Authority to take homelessness applications, or reinstate council provided services if withdrawn and to appropriately review at the level of sustainability of off-site education provision. These remedies can often be more flexible and action based than those provided by the High Court.

21. The flexibility of Ombudsman remedies is demonstrated in the following examples of mitigating injustice to the complainant: installing double glazing for certain parts of the house to mitigate noise or arranging extra provision in respect of provision of speech and language therapy.

22. The PHSO's *Principles for a Remedy* also provide "An appropriate range of remedies will include remedial action, which may include reviewing or changing a decision on the service given to an individual complainant; revising published material; revising procedures to prevent the same thing happening again; training or supervision of staff or any combination of these".

23. The guidance suggests that the Ombudsman will take the following approach where a process based remedy would not adjust an injustice or aspects of it. First, the Ombudsman will ask whether a direct compensatory payment can be made to meet quantifiable loss. The only case to consider local government ombudsman remedies in any detail in Bernard v London Borough of Enfield [2002] EWHC 2282 (Admin) which contains a good example where Mr Justice Sullivan mentions:

"… the highest recommended award (£16,350 at current values) included a significant element of pecuniary loss. The complainant had been unable to find a suitable job because we care commitments, had sought medical treatment for depression, had exhausted her substantial savings and was reduced to living on income support, the previous standard of living having disappeared."

24. There are a number of examples of reports such as report *97/A/1315* against Kent County Council and a series of reports against the London Borough of Southwark which identified these particular pecuniary losses. Where the complainant has not suffered an easily identifiable financial loss, the default approach in assessing current financial compensation is to consider what the cost of acting without maladministration would have been to the authority. There is an obvious logic to this as the lost value can be easily calculated and authorities should not profit from their own maladministration. However, the lost value approach is not always strictly followed and there may be reductions to the figure. The guidance on *Good Practice: remedies* emphasises that "other relevant factors" should be taken into account, such as "to mitigate aggravating actions by the person affected or third-party affected by the injustice". The PHSO's guidance similarly emphasises that, when considering a remedy it is reasonable for a public body to take into account any way in which the complainant has contributed to or prolonged, the injustice or hardship. This guidance emphasises the responsibility for injustice may not live exclusively at the public bodies' door.

25. As the Ombudsman will accept that complainants will often been put to expense of pursuing complaints that should not been incurred but for the maladministration these can include legal costs and other professional fees.

26. In some instances the LGO had made recommendations for full reimbursement of solicitor's costs at private rates notwithstanding the case been run on a legal help basis. The classic example is complaint 3/A/15819 against the London Borough of Waltham Forest where the client was a refugee who could not have been expected pursue a complaint unassisted.

Indirect redress

27. Apart from direct financial loss of the value of the lost service, an Ombudsman will recognise service failure may have caused other consequences which call for financial compensation. This is recommended in addition to direct redress. For example, in a report into maladministration concerning Government publicity

materials for occupational pension schemes had misled members about their security.

28. Sometimes only one or other type of payment is considered appropriate. Ombudsman reports have consistently identified two consequences which call for particularly significant compensatory award (1) loss of childhood proper family life; and (2) distress.

    The guidance on *Good Practice: Remedies* comments

    "Contextual circumstances

    Others may been affected by the body in jurisdictions fault. If there is evidence to suggest this, we would usually recommend the body in jurisdiction identifies those similarly affected by its fault offers an appropriate remedy for injustices caused. We may also ask the body in jurisdiction to tell us what action is taken. But in some cases it may be in the best interests of those affected for the LGO to investigate the impact and recommend a remedy".

29. Remedies can now be recommended for those who have not complained but are similarly placed, pursuant to section 26 the Local Government Act 1974.

    In Principles for a Remedy the PHSO states:

    "6. Seeking continuous payment improvement

    Part of a remedy may be to ensure that changes are made to policies, procedures, systems, staff training or all of these, to ensure that the maladministration or poor service is not repeated. It is important to ensure that lessons learned are put into practice.

    It is a false economy and poor administrative practice to deal with complaints only if they arise and to fail to correct the cause of the problem. Learning from complaints, and offering timely and effective remedies, gives the best outcome in terms of cost effectiveness and customer service – benefiting the service provider, the complainant and the taxpayer.

    The public body should ensure that complaint receives: an assurance that lessons have been learned an explanation of changes made to prevent maladministration or poor service being repeated.

> Quality of service is an important measure the effectiveness of public bodies. Learning from complaints a powerful way of helping to develop the public body and increasing trust amongst the people who would use its services. So systems should exist to: record, analyse and report on outcomes of complaint and remedies apply the information to improving customer service."

Examples of recommendations for systemic change

30. The approach of the Ombudsman to make recommendations for systematic change is as follows.

31. In complaint number *12 006209 Liverpool City Council* in which the LGO during the course of its investigation discovered the council had been routinely miscalculating the appropriate level of special guardianship allowance. In addition to providing a remedy to the complainant, who had been paid too little for the period, the LGA recommended that payments be awarded 246 other people in respect of special guardianship allowance and appropriate level of fostering allowance in further hundred and 94 cases

32. Complaint *10 020 600 Warrington Borough Council and the NHS Warrington* this was a joint investigation by the LGO and PHSO into a complaint that a boy with autistic spectrum disorder not been provided with speech and language therapy as specified in a statement of special educational needs over a period of three years. In the course of the investigation, the LGO identified a further 15 secondary school pupils have been affected by the council's failure to fulfil its statutory duty and recommended the council apply the remedy in this case to the other children who had been affected.

33. Finally, under in a pensions matter, in the report *Trusting the Pensions Promise*, which concerned maladministration which may have impacted 125,000 people 200 complaints were are accepted with four representative lead cases the findings were made in respect of cases actually investigated but recommendations were for redress for the class as a whole so it can be seen of the potential for the Ombudsman's remedy being very powerful.

C. The process of making an effective complaint

34. So how does one go about making a complaint and what are the specific issues that have to be addressed?

35. First, an Ombudsman will generally not accept a complaint if it is subject to court proceedings.

36. Secondly, a public body's' complaints procedure must be exhausted. For example, if you want to complain about social services you must make a complaint using their internal procedure before you can complain to the LGO. This is to give the public body an opportunity put things right first and unless there is a good reason why the internal complaints procedures has not been used the Ombudsman will generally refuse to investigate the complaint.

37. Thirdly, the PHSO is different because there is at present no mechanism for an ordinary member of the public to bring a complaint directly other than through the MP filter. So a constituency MP has to bring the matter to the attention of the PHSO.

38. Fourthly, the complaint must be brought within the usual required time limits usually within 12 months of the date of action complained of. However, if more than a year has past because the complainant has been using the internal complaints procedure the Ombudsman will generally still consider the complaint, but it needs to be made clear to the Ombudsman the complaint is being brought as soon as the internal complaints procedure is finished if it is already outside the 12 month limit. Generally the LGO has a general discretion whether to investigate if the complaint made out of the 12 month time limit and there needs to be an explanation as to why that discretion is to be exercised or not. In making the complaint it is for the complainant to ensure that they have exhausted all the internal complaints procedures. This can be dealt with by checking the procedural requirement precisely with the particular Ombudsman before issuing the complaint.

39. The process:

    a. First determine whether they have a particular form to use although generally a complainant can just write a letter;

    b. At the outset the complaint should clearly set out the following;

        i. The name and address of the complainant and any details of any advisers;

        ii. The details of the which public body department and specific people complained about;

iii. The factual details with a short chronology can help setting out the main events and when they happened;

iv. Identify what is thought to be the maladministration using the various types of headings. Itis often useful to refer to any documents publicly available from the public body giving timetables or performance indicators, for examples “we will inform you of X in 14 days in writing” often these can be found on the public body’s website;

v. Whether the complaint may have a wider impact on other people and how this has caused the complainant injustice.

vi. Also include details of the complaints already made and the outcome of any investigations, and provide copies of any relevant documents of importance;

c. It is essential to try and make any explanation as short and clear as possible. The focus should be on the main issues that are to be complained about and should try and leave out irrelevant details. One the key documents to try and find from a public body is a document that relates to targets or standards of service provision and how this has been departed from;

d. It is very important that a copy of the complaint is kept by the complainant.

The investigation

40. When an Ombudsman investigates the first thing that the Ombudsman will look at is whether they have jurisdiction on the complaint. This means whether the public body and the decision complained about is something the Ombudsman can deal with. If the Ombudsman considers they have jurisdiction they will then make a decision whether or not to investigate.

41. The Ombudsman is not obliged to investigate all complaints even if they do have jurisdiction and can refuse for various reasons, for example, if they think that it's purely a legal matter which it falls outside of their remit. They can say there is another remedy, either by suing the local authority or public body or by seeking judicial review of the decision complained of.

42. The next step, once the Ombudsman has decided that the complaint is within their remit, it that they will investigate it and consider whether it can be dealt with informally, by contacting the public body to look for a local resolution. If local resolution is not successful they start a full investigation which includes contacting the complainant for more details, interviewing the relevant people at the public body and obtaining all the relevant documents from the public body.

43. Once this stage of investigation is complete and the investigator produces a draft report that it is sent to the complainant and the public body to comment on. At this point in time it is useful to examine the draft report for mistakes or any factual issues to be raised, or issues which are not covered, or new evidence to be provided and considered. This is a vital point because this gives an opportunity for the complainant to comment on the draft report and ensure that the complaint is dealt with effectively.

44. When the investigator has received comments they should finalise a report including their recommendations and send it out setting out the findings made and, often, the recommendations are agreed in advance with the public body which can include getting the public body to do what should have done.

45. The Ombudsman does not have the power to force a public body to comply with recommendations but it is a very rare indeed from public bodies not to follow the recommendation. The public bodies are also required to report back to the Ombudsman if the recommendations are included in a review of their policies and procedures.

Requesting a review of the ombudsman's decision

46. Even when there is a confirmation of the outcome of the Ombudsman's investigations, the complainant may not agree with the findings or the recommendations. The best approach is to address this to the Ombudsman as to what has gone wrong.

47. The three key questions will be (1) did the Ombudsman find maladministration (2) did the Ombudsman find injustice caused by the maladministration and (3) do the recommendations and the remedies match the findings.

48. There is an opportunity for the complainant to request the Ombudsman review the decision. This will need to explain to the Ombudsman clearly why the Ombudsman has gone wrong. For example, if the recommendations were not fair in relation to the findings maladministration the best thing to do is look to see

if there are similar types of decisions on the Ombudsman's website so that you can refer the Ombudsman back to their previous decisions in similar cases in respect of maladministration and consistency.

49. Also each Ombudsman has its own complaints procedure and this can be used to challenge an investigation which has gone wrong. The ultimate challenge would be a judicial review of the Ombudsman's decision on a point of law.

D. The Patients Association and the PHSO

50. The Patients Association have produced several reports on the PHSO. In a report in November 2014 the Patient's Association stated as to how it felt the PHSO failed patients and families. The document is quite long and it makes several findings which are summarised at page 35 to 36.

51. The document makes the following findings:

    a. First the jurisdiction the PHSO is unclear, leaving ill-defined boundaries between the organisation and other public bodies such as the care quality commission;

    b. The PHSO hides its failings behind legislation;

    c. Individual cases take far too long to be assigned to be investigated and, subsequently investigations are too lengthy;

    d. The current process relies heavily on families bearing the burden of evidence. If evidence is not presented by the families, the PHSO does not act to find it;

    e. There are too many gaps involving clinical decisions that the PHSO refuse to investigate, therefore families fall into a bureaucratic no man's land, for example, cases under the Mental Health Act or in cases of clinical decisions of "do not attempt resuscitation";

    f. The right people with the right skills are not always assigned to cases and as a consequence this can negatively impact on the outcome of the investigation;

    g. The investigations are not diligent, robust or thorough;

h. The PHSO investigators failed to appropriately consult medical and clinical advisers who might be able to help them;

i. Complainants are often refused the chance to meet with the person investigating the case, in order to explain their concerns, agree the terms of reference investigations, time scales and communications pathways;

j. The PHSO fails to acknowledge that many relatives have evidence of intimate knowledge of the care received by their loved ones and hold detailed facts related to their particular care case;

k. The PHSO also declines requests from families for additional crucial information evidence to be submitted once a written complaint has been made and an investigation has begun. They frequently ignore evidence from families and carers;

l. Linked to this there is evidence of the PHSO investigation conclusions not being entirely evidence-based. Crucial mistakes in investigations resulting in poor decisions and recommendations;

m. As a consequence, the PHSO continually makes errors of judgment and mistakes, which ultimately leads to re-investigations, which then result in additional cost the public purse and considerable further distress to families;

n. The PHSO compound their errors by frequently reassigning the same investigators to carry out re-investigations. As a consequence, mistakes made first time round remain unchallenged and are even on some occasions repeated. Investigators are in effect in reinvestigating themselves;

o. If and when in the PHSO appeal process agrees to a reinvestigation and despite the possession of all the original paper's in the initial investigation, the families are expected to submit all relevant papers all over again and have only 42 weeks in which to do so;

p. The PHSO requires families to keep the outcome of draft reports confidential under a dubious application of the law;

q. Families are not consulted prior to finalisation of reports of the consequences, have no influence or say regarding the final

recommendations. Even where recommendations are made, there is little evidence to say that they followed up, reviewed, or NHS Trusts are held to account in implementing any recommendations;

r. Throughout the whole PHSO process, families are left distressed, exhausted and distraught by the failings of the body carrying out public functions and which are not investigated in an efficient, effective and caring manner;

s. In real terms the total cost to society and families of the PHSO far exceeds £40 million funding the body received. The PHSO appears unaccountable and untouchable.

52. The report makes several conclusions and recommendations.

a. It was time to for an independent review of the role and public accountability of the PHSO;

b. Legislation applied to the PHSO should be reviewed;

c. The statutory duty which requires the NHS trusts to adhere to the principles of being open should be extended to the PHSO in handling complaints;

d. Clearly defined organisational boundaries and jurisdictions must be established;

e. A review of case case-by-case costing by the National Audit Office;

f. Opaque paper-based procedures need to be completely overhauled;

g. An independent appeals process for investigations;

h. Terms of reference for each investigation must be agreed with families on commencement of the investigation;

i. A review of timelines the completion of investigations;

j. Face-to-face meetings with complainants at the commencement of the investigation;

k. Agreed regular face-to-face meetings with complaints at each stage of the investigation;

l. Independent advocacy support available for all complaints;

m. Timelines for submissions of appeal must be extended;

n. It should not be under the remit of the PHSO to recommend monetary settlements to complainants;

o. To ensure learning the PHSO must influence change and ensure trust following appropriate investigation.

53. The Patients Association produced a follow-up report in March 2015 and to progress in respect of the considerations by the Public Administration Select Committee and recommendations as to a way forward.

54. In the way forward I refer to Felicity Williams as to the Gordon Report with the proposals in the Queen's speech as to a new Ombudsman's Bill.

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