Written evidence from David Czarnetzki (PHS 04)

Public Administration and Constitutional Affairs Committee
Parliamentary and Health Service Ombudsman Scrutiny 2019-20 inquiry

Key points of evidence

- **THE CUMBERLEGE REPORT - FIRST DO NO HARM**
- **RADIO OMBUDSMAN – A VANITY PROJECT?**
- **PHSO NON-COMPLIANCE WITH DATA PROTECTION/FREEDOM OF INFORMATION**
- **HEALTH SERVICE COMMISSIONER (Complaint Handling) ACT 2015**
- **CIVIL SERVICE CODE**

The 2020 report by Baroness Cumberlege entitled "First do no harm".

This report includes:

Page 10 Para 1:30

*"We do not need another regulatory body in an already crowded field, but we do need a **NEW** voice with statutory powers to act from the perspective of the patient".*

The report recommends the appointment of a Patient Safety Commissioner.

Page 201 Para 8:

"There is a number of opportunities to improve patient safety across a wide range of organisations. At the same time it is a crowded landscape that can stand in the way of timely response".

Page 206 Para 25:

"Legislation would prevent the Commissioner from investigating individual cases as this would duplicate the work of the Parliamentary and Health Service Ombudsman".

I broadly welcome the report of Baroness Cumberlege and agree there should be a Patient Safety Commissioner. However, rather than duplicate the work of the Ombudsman, the Commissioner should replace it, leaving the Ombudsman to deal with Parliamentary issues only. His budget could then be further reduced rather than increased as he has requested,, making way for PHSO amalgamation with the Local Government Ombudsman (LGO).

PHSO and LGO should not have involvement in health or social care issues.
The Commissioner should then investigate individual cases, with power to intervene at an early stage and operate in partnership with the Health Safety Investigation Branch, building on professional expertise. The Ombudsman lacks such expertise and

has to rely heavily on external clinical advisors, whose identity is still secret from complainants, despite previous 'reviews'.

This secrecy remains an issue for complainants.

Radio Ombudsman

Page 18 of the Ombudsman's report to Parliament states:

"The Radio Ombudsman podcast has reached thousands of listeners since it was launched in 2017".

The Ombudsman hails this as a success story. It is nothing but an example of broad based 'spin'. Detailed analysis shows a different picture - one of falling interest of the public. Other Ombudsmen working in their own sectors have not followed his lead. The 19 podcasts produced so far have been played a total of 5991 times, broken down as follows:

Podcast Number	Guest	Number of plays	**Average plays**
1	**Scott Morrish**	1097	
2	Michael King	404	
3	Sarah Barclay	313	
4	Sir David Behan	360	**Podcast 1-5**
5	Emily O'Reilly	291	**493**
6	**James Titcombe**	434	
7	Claire Murdoch	371	
8	Henrietta Hughes	258	
9	Sir Liam Donaldson	248	**Podcast 6-10**
10	Jenna Brown	206	**303**
11	Marie Anderson	302	
12	Rachel Power	259	
13	Rosemary Agnew	335	
14	Rebecca Holsenrath	274	**Podcast 11-15**
15	Peter Tyndall	189	**271**
16	Dr. Tony Disart	164	
17	Rafael Rib	177	
18	Ian Trentholm	187	**Podcast 16-19**
19	Sir Robert Francis	122	**162**

(Source of statistical information provided by PHSO's FOI officer).

I conclude this has rapidly become a waste of the Ombudsman's time and taxpayer's money. Page 87 of the report shows the Ombudsman has 389 full time equivalent staff. It is clear even they have little interest in using this particular medium of communication.

It is worthy of note the two highest numbers of plays relate to Scott Morrish and James Titcombe – people who imparted direct patient experience. PACAC should be

concerned the last four podcasts attracted, on average, less than one third of plays compared to the first five.

Data Protection and Freedom of Information

At the last PACAC hearing, the Ombudsman informed the committee he had reported himself to the Information Commissioners Office (ICO) for a major breach of confidentiality affecting many people. We have yet to see how the Information Commissioner has viewed this breach. The Ombudsman continues to adopt a lax attitude to Data Protection and Freedom of Information legislation.

Examination of the Information Commissioners Office website reveals the following breaches in addition to the self reported breach above:

12th June 2019 – Breach of Section 1 – Data Protection Act – Case FS50800867

14th October 2019 – Failure to respond to request for information contrary to Section 10 – Case FS50876040

9th September 2020 - Failure to respond to request for information contrary to Section 10 – Case IC-44708-K6M7. (request made to PHSO in November 2019).

I expand on the 9th September 2020 case as follows, having been directly involved:

In this case, the Ombudsman failed to comply with County Court procedures in a timely manner, initially resulting in a Judgment in Default of £4,537 being awarded against him, and led to the proceedings becoming more protracted. This necessitated two hearings at Telford County Court under the small claims process. I quote directly from a letter to me dated 31st October 2019, signed personally by PHSO's Chief Executive Officer.

"Throughout your legal proceedings, we notified you that your claim had no legal merit and that you had no legal grounds to claim compensation from us….. You have referred to the court entering judgment in default, but this related only to the administrative difficulties in respect of the court being able to take the fee for our application to strike out…We have since had to incur substantial costs, from public funds, defending your unsuccessful claim against us".

It was this letter that prompted me to find out precisely how much PHSO had spent on barristers attending two short County Court small claim hearings at Telford and I made the freedom of information request on 6th November 2019. Despite the request being acknowledged by the Chief Executive, it went unanswered, forcing me to complain to the Information Commissioners Office. They upheld my complaint and issued a decision notice on 9th September 2020 requiring PHSO to release the information by 16th October 2020. On Thursday 8th October 2020, nearly a year after the original request, PHSO complied with the decision notice and confirmed the cost of barristers was £1,933.94.

PHSO has its own in house legal experts it could have used. It was unnecessary to incur substantial external legal costs in a small claims matter, which neither side can

recoup, and then arrogant to castigate a complainant as being responsible for incurring costs to the public purse in the process. I remain frustrated PHSO put me to considerable financial expense for which I have not been fully compensated.

In her letter of 31st October 2019, the Chief Executive passed off the judgment in default as being awarded as a result of 'administrative difficulties'. PHSO acknowledged service of documents on 12th June 2018. I have a letter dated 11th July 2018 from the court to PHSO, date stamped as being received at PHSO on 13th July 2018, stating they tried to contact PHSO on three previous occasions before writing the letter and then issuing the judgment. There were no administrative difficulties within PHSO – only incompetence! The PHSO Chief Executive should acknowledge this.

These cases demonstrate the Ombudsman does not have a sufficiently robust procedure in place. When requests are made for information to be supplied, legal timescales have been ignored. It then falls to the ICO to conduct an investigation. The Ombudsman appears indifferent to the overall cost of his non-compliance to the public purse and might better use his time focused on addressing the failures of the organisation rather than making vanity podcasts for which there is a waning appetite.

Page 97 of the Ombudsman's Annual Report shows PHSO paid £42,000 compensation in 27 cases. As a result of how the Ombudsman decided my compensation for his failings in my case, I can fully appreciate how he arbitrarily imposes compensation figures without due regard to the considerable expense he puts complainants to in their search for truth and justice. At no time did he contest £4537 was the wrong figure. He just wouldn't pay it and it is now clear the complainant has no redress against such autocratic and arbitrary decisions. Instead, he would rather spend nearly £2000 on barristers – a sum he could not recoup.

The public will take no lessons in cost saving from this particular Ombudsman whilst he acts in such a way.

Health Service Commissioner for England (Complaint Handling) Act 2015

This short Act of Parliament has one section and three subsections. It requires the Ombudsman to disclose:

- Subsection 3(a) How long investigations that were concluded in the year to which the report relates took to be concluded
- Subsection 3(b) How many of those investigations took more than 12 months to be concluded
- Subsection 3(c) The action being taken with a view to all investigations being concluded within 12 months.

This Act relates to investigations – not help line enquiries.

Page 12 of the Ombudsman's report states there were 254 cases over 12 months old in March 2020. The report does not identify the date these complaints were initially received, nor does it give any indication of how many complainants were sent to letters under the requirements of sub-section 2 of the Act.

The Ombudsman frequently extolls the virtue of his organisation being open and transparent. So the real question to be addressed in PACAC scrutiny of the Annual Report is how many cases are now over more than two, three, four years old or longer. The Act itself can also be viewed as counterproductive as far as complainants are concerned and may go some way to explaining why there is a growth in cases not being selected for investigation. Fewer investigations means fewer cases risk taking more than 12 months to close!

The issues surrounding PHSO performance are both historic and ongoing. They have been on the radar of complainants for many years. It remains inconceivable that PACAC can adequately address them within an annual scrutiny session. The key points I ask PACAC to take forward are:

- PHSO should not have responsibility for Health or Social Care complaints. They should become the responsibility of the Patient Safety Commissioner proposed by Baroness Cumberlege. The Commissioner must be given statutory power to investigate individual cases, with a specific power to intervene at any time, including **before** NHS trusts have completed their own investigation. Various reports have identified too many cover-ups in recent years.
- The work of Baroness Cumberlege should be developed with greater emphasis on the failings of PHSO rather than the one sentence her report contains (I accept this may have been outside her original terms of reference)
- The urgent need for legislation and reform to correct this decades old archaic system, described by Quintin Hogg in parliamentary debate in 1967 as "a swiz".

I note the Chair of PACAC has written to the Chancellor of the Exchequer in support of the Ombudsman's request for increased funding. I would suggest that, looking at the ratio of cases the service has in relation to Health and other Government departments, his budget could be cut to about £4 million and the remaining money

allocated to a new body capable of doing the job of health and social care investigations properly. This would then lead to the amalgamation of the Parliamentary and Local Government Ombudsman to become the one service currently under consideration.

Since the PHSO investigation into my own complaint commenced in 2014, I have followed how PACAC 'scrutinise' the Ombudsman. Looking back over the submissions made by the public, including the rare occasions when the committee has invited verbal evidence from them, it is clear PACAC has not been a conduit through which the necessary change is likely to be created.
Overwhelming evidence of a need for urgent and substantial change has been placed before PACAC. Maintaining the status quo runs a risk of allowing the Ombudsman down a path to becoming a dictator, hiding in plain sight, in our democracy. It is for politicians to bring that change and accountability about and, with respect, it needs to be progressed if appropriate learning is to take place and avoidable deaths in health and care settings averted.

Civil Service Code

A wider audience may not be as aware and knowledgeable as PACAC of the Civil Service General Principles of Conduct and Standards of Behaviour which includes:

- deal with the affairs of the public, sympathetically, efficiently, promptly and without bias or maladministration
- not fall short of the professional standards expected.
- fulfil duties and obligations responsibly
- always act in a way that is professional and that deserves and retains the confidence of all those with whom you have dealings
- deal with the public and their affairs, fairly, efficiently, promptly, effectively and sensitively, to the best of your ability.

The book entitled "What's the point of the Ombudsman", published in June 2020, provides ample evidence of the Ombudsman's systemic failings. If the system were working well, the book would not need to have been written. A copy of the book has been supplied to PACAC. It is essential reading if the failings of the Ombudsman are to be truly understood. His compliance with the code is highly questionable. The Ombudsman also attracts derisory ratings on Trust Pilot.

Whilst PACAC do not generally look at individual cases, it is individual cases, such as those referred to in the book mentioned in the previous paragraph, which lead to the inevitable conclusion that, despite each being in post for over three years, the Ombudsman and his Chief Executive are not the right people to turn this organisation round.

PACAC ask for evidence relating to PHSO regarding:

- value for money
- impact on other organisations
- time taken to respond to correspondence, SAR and FOI requests.

Committee members will see from this submission:

- Radio Ombudsman is a waste of money
- PHSO inefficiency places an unnecessary extra work load on the Information Commissioner and the Courts
- The response to communication remains appalling (as evidenced in the response to the County Court and my FOI request)

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