Written evidence A4 (PHO34)

Public Administration and Constitutional Affairs Committee
Parliamentary and Health Service Ombudsman Scrutiny 2020-21 inquiry

The case I brought to the Parliamentary and Health Service Ombudsman (PHSO) related to a number of failures by a National Health Service (NHS) Trust. It was so badly dealt with that it added considerably to the anguish I had already experienced. At the conclusion of my case the Parliamentary and Health Service Ombudsman (PHSO) has not admitted to maladministration, only of 'short-comings' in its investigation. However, in dealing with my case the numerous examples of PHSO failings are prime examples of the types of maladministration listed in the 'Crossman catalogue'. Few of these issues were addressed or considered in the investigation or the review.

Progress with my case was extraordinarily slow. Frequent delays to updates were up to four months apart and the reasons were given for the delays were vague and absurd. Timeframes and delays would favour the NHS Trust but sometimes pressurised and inconvenienced me. I thought it unreasonable given the delays imposed by the PHSO that the caseworker would not extend deadlines for the submission of my evidence. The investigation took over a year and while the subsequent review took two years it was only during the last six months that any tangible activity took place.

Much of my enlightenment to PHSO's unusual interpretation of 'impartiality' was due to the subject access requests (SAR) I made. Like most aspects of the PHSO service I received there were some problems with SAR requests. The first request had been logged and the information rights team were to contact me after the final report but did not. After I had made a fresh SAR it arrived after a month but several documents were missing and many documents did not bear a date or it had been removed.

During the investigation the PHSO showed complete disregard for my evidence without reason yet needlessly requested further evidence and asked me to describe or re-send documentation already in its possession. Hence when making decisions the PHSO failed to take into account all the facts not least because it witheld medical records from its clinical advisor (CA). The PHSO also witheld material evidence from me until after the final and review reports and would say one thing then deny ever having said it, despite documentary proof.

The non-medically qualified caseworker participated in medical diagnosis of his own by surfing the web, his motive was clearly 'how can we explain away… xzy'. Yet the PHSO without further explanation nor reason declared my own professional clinical advisors as not being relevantly qualified to comment on the case. My clinical advisors comprised of a retired GP & ex-Director of Public Health with extensive experience and qualifications and a Nurse Prescriber with higher qualifications than the PHSO's own CA. Despite promising to carefully consider my adviser's comments the PHSO declined to comment on either. It therefore applied neither the civil standard of the 'Balance of Probabilities' when considering my clinical advisors reports - nor its own 'Balancing Evidence Guidance':

3. We will explain the evidence we have considered and why.' and
3.2 We will explain how the advice we have sought has been applied to the complaint'
3.6 We will share (on request) the evidence we have considered.'

In fact, many of the assurances promised in PHSO quality of service charter documents were also noticeably absent. With the typical arrogance of the unaccountable, the caseworker refused to answer reasonable questions and would not direct me to where I may find the information myself. I frequently found such refusals unhelpful, rude and abrupt. Or my question would be ignored. He also advised me that several PHSO 'principles' *do not apply to the reviews of investigations that the PHSO carry out*. Therefore for instance, the key performance indicators (KPIs):

6. explain the specific concerns we will be looking into;
7. explain how we will do our work
8. gather all the information we need, including from you and the organisation you have complained about, before we make our decision;
9. share facts with you, and discuss with you what we are seeing

- do not apply to PHSO reviews of its decisions.

During the investigation and review the caseworker promised but then retracted offers to: a) supply copies of communications with NHS Trust b) expand the scope of the investigation. c) to keep me updated at whatever frequency I preferred. d) to listen to my comments and make changes before the final report e) to supply material evidence with the review report.

Is there any equity at all in how the PHSO handle cases? It argued against every point I made and ignored my evidence. The caseworker refused to explain his reasoning on his decisions. Neither has the PHSO given explanations in the review as to how the frequent and consistent errors of judgement had occurred nor why most of my concerns and evidence were ignored or improperly and unfairly considered during the investigation. Like many other complainants I was ‘disbelieved by default’. For instance the caseworker was ready to dismiss one issue because the NHS Trust had deleted my emails, even though I had supplied copies to the PHSO. My pleas for the PHSO to look at a specific documents were ignored, the PHSO subsequently provided selective evidence to the CA to consider and posed general questions to her, avoiding the main issue. In support of the caseworker the anonymous NHS / PHSO-employed CA said that the missing documents were irrelevant to her analysis, but this was later over-turned. The caseworker would subsequently apply his 'interpretation' of the CA's reports. This involved vague unsupported guesses, various rewording and in a couple of instances, complete fabrication.

The caseworker also notified the NHS Trust that I intended to be making a SAR, assured it I had been delayed in this request and asked if there were any objections to its communications being shared. There was further conspiring during the investigation when the caseworker and superior debated whether to withhold CA reports (material evidence) from me until the final report. Similarly, CA reports that informed the review were witheld during the review and not supplied with the report. I believe that was contrary to that stated by Amanda Amroliwala in the 2020 PHSO PACAC Scrutiny Meeting:

"...not only will we produce that material evidence and explain how we have used it, but if we have not relied on something that has been provided to us, we will also explain why we have not relied on that evidence."

In the review of its decision the PHSO claimed it did not know how or why the caseworker had made the (fraudulent) decisions he had made and admitted that the CA's analyses could

not be relied upon. The PHSO gave no indication of any penalties or 'feedback' to the CA for overlooking evidence.

Concerning the NHS complaint, the ambulance service had identified many symptoms related to the patients condition yet the Hospital Accident and Emergency Department (A&E) staff misdiagnosed the illness as a much less-serious condition. They had made this misdiagnosis despite abnormal findings on the X-Rays, ECG, blood test readings, pulse rate and serious heart irregularities. The NHS Trust had untruthfully reported that all the blood tests were normal and the PHSO concurred. The PHSO also untruthfully claimed that the ECG did not provide evidence of a serious condition and that the misdiagnosis was a reasonable one.

The PHSO and the CA concentrated effort in defending the two misdiagnoses and poor hospital care and worked hard to disprove my views and avoid my evidence. Both argued with unreferenced opinion against my documented proof including reports from my clinicians. The PHSO rejected outright the professional advice and the amply documented proof, merely stating it wasn't 'good evidence' with the usual PHSO mind-boggling mantra "*you provided no evidence*". I did, and it was worthy of consideration at least. To support its claims the PHSO made absurd and insulting guesses despite the evidence of the symptoms present and anatomical location. It made outrageous guesses regarding the skill of the ambulance staff *akin to saying* that 'heart-attack' in the paramedic's notes probably meant 'heart-burn'.

The PHSO declined to request apologies from the NHS Trust for its failure to report a serious incident and for the long period of unecessary pain induced by a clinical error. The PHSO offered a 'payment' of just £250 and this was only *"for our delay in dealing with your review request and for failings in our updates to you on this."*

The Parliamentary and Health Service Ombudsman is not fit for purpose. A waste of time for the complainant and all involved. In terms of my case, it has wasted money and resources through its bias and incompetence. After years of delays to its decisions, the unpleasant experience just adds to the original distress and hence it provides little or no closure for this complainant.

October 2021