

An 'other' report by the Scottish Public Services Ombudsman about a Report¹ on the handling of a complaint (200502514) by the SPSO

Background

On 16 August 2009 I commissioned an external review of the handling of an SPSO investigation into a complaint. I informed stakeholders of this exceptional step in my Commentary on 19 August, in which I wrote:

'One report (Case 200502514) that I am laying before the Parliament today has been with the SPSO for around three years. I regard such delay as unacceptable both for the complainant and the local authority involved, and generally as being contrary to the SPSO's aim of arriving at fair and speedy decisions.

I have therefore asked Jerry White, one of the Local Government Ombudsmen in England, to review the handling of this case and to advise me on particular and general lessons to be learned for the SPSO in the areas of investigative process, stakeholder engagement and reporting.'

I committed to publishing Mr White's report, and am doing so by means of laying an 'other' report in Parliament under section 17(4) of the SPSO Act. I believe this step is necessary to the exercising of my duties to ensure confidence in the complaints process and to be able to address and report on problems transparently (particularly to the Parliament, to which I am ultimately accountable).

The Report

This week I received the report of the independent review that I had commissioned. I am very grateful to Jerry White for his thorough examination. His report makes for sobering reading for us, and, while noting that it is about the handling of one specific case at a particular point in time, the report confirms my view that despite a great deal of change that has taken place over recent years, there are some aspects of the organisation's complaint handling process that need attention.

Mr White groups his findings into five areas – First Contact, Investigative Focus, Management, Communications with Stakeholders and Reporting. Failings in each area are identified. I accept all the findings without reservation.

My response

1. Apology

I have made an unequivocal apology to the complainant and the council concerned for all the failings on the part of the SPSO that are identified in the report. We clearly fell very far short of the standards that we have set for ourselves and other public bodies. I apologise unreservedly for these mistakes.

The guidance and procedures that were in place at the time this complaint came to our office have changed and improved a great deal in the intervening period. I believe that some further action is required and set out below what I intend to do to prevent any recurrence of the problems identified in Mr White's report.

¹ Mr White's report is attached as Annex 1. It is published in full with minor amendments resulting from legal advice on data protection issues. Appendix I of Mr White's report has been withheld because it presents issues under the Data Protection Act relating to the possible identification of SPSO employees.

2. Rules of engagement with MSPs

The report finds that the involvement of the MSP was mismanaged by the SPSO. It also makes clear the need to protect the independence of the Ombudsman and as importantly to ensure the visible independence which must be displayed to maintain public confidence. I am, therefore, drawing up internal guidance for SPSO staff in proper rules of engagement and interaction with elected members generally so that we can ensure that actions of the SPSO are independent and are seen to be so.

3. Building in safeguards

We ask public bodies to take action to ensure no recurrence of the problems that gave rise to a complaint upheld about them. Naturally, the public has the right to expect us to hold ourselves to the same account. I certainly do, and the lessons in Mr White's report will inform the internal review of the SPSO which I began in August.

The scope of the review, which will report to me on 9 October 2009, is 'to review all aspects of SPSO complaint handling policies, guidance, procedures and practices within SPSO, including challenges, appeals and complaints about our service, and to produce revised policies and a structure which will be customer focussed, cost efficient and deliver excellent service to complainers, bodies under jurisdiction and will take account of the needs and aspirations of all our stakeholders.'

Jim Martin
Scottish Public Services Ombudsman

2 October 2009

REPORT
on
THE HANDLING OF A COMPLAINT [200502514] AGAINST NORTH
LANARKSHIRE COUNCIL BY THE OFFICE OF THE SCOTTISH PUBLIC
SERVICES OMBUDSMAN [SPSO]

My Remit

1. I was asked on 16 August 2009 by James Martin, Scottish Public Services Ombudsman, to conduct an independent review of the way in which the SPSO had handled the above complaint. I was particularly asked to give my views on 'the lessons that SPSO can learn around the investigative process, reporting and stakeholder engagement in this case'. I was provided with the complete case files held in respect of the complaint and I have used these as the basis for my report.
2. I have not considered it necessary or appropriate to compare in detail what actually happened in respect of this case with the SPSO's investigative procedures. I understand from Mr Martin that these are to be reviewed in any event. Accordingly, I have confined my report to the major lessons which I feel can be learned from this case as a way of informing the SPSO's further work on procedural matters.

Summary

3. On 8 December 2005, SPSO registered a complaint from Mrs C about the way North Lanarkshire Council handled complaints she had about her children's school. The SPSO's investigation was concluded by way of Report on 19 August 2009, some three years and nine months after that complaint was received.
4. I attach at Appendix 1 a chronology of main events over this period; and at Appendix 2 the main investigative milestones, by way of summarising the more detailed chronology.
5. I conclude that the SPSO's handling of the complaint was characterised by very considerable delay and confusion. Bluntly, it is the worst case of complaint handling by an Ombudsman's office that I have seen.

6. I am conscious that what I have been asked to review may well be a one-off event, or at least far from typical. I am also aware that this case went badly wrong from the very beginning, and that if it had been better dealt with from the outset much of the later confusion and complications would probably never have arisen. Despite these peculiarities, which may well be case-specific, I hope I have been able to identify some issues of more general significance that might prove useful to the SPSO in reviewing its office arrangements for the future.

Main Lessons

7. I have grouped these under five headings: first contact between SPSO and the complainant; investigative focus; management; communications with stakeholders; reporting.

FIRST CONTACT

8. Early discussion between the SPSO and the complainant, ideally over the telephone, would have helped manage expectations and clarify issues from the outset. There were a number of complexities here that could have been introduced to the complainant at this stage.
9. The substantive complaint about the school was outside the SPSO's jurisdiction. It could only look at the way the Council handled complaints about the matter and could not itself investigate the school or what had gone on there. That alone limited just what the SPSO could achieve for the complainant, and it would have been helpful for this to have been discussed at the outset.
10. There were several components to the complaint. It would have been beneficial to have clarified at the outset just what injustice was claimed from the Council's alleged failings and which most worried the complainant.
11. The possibility could also have been explored as to whether early intervention by the SPSO with the Council might have secured some swift resolution, for instance through a meeting at senior level or mediation involving the Council and the school. That may not have been possible, and it clearly was not an option later on; but may have been an alternative means of resolving the dispute before views became completely entrenched.

12. Finally, this would also have been an opportunity to explain what would happen next in the SPSO's office and how it was intended that the complaint would be handled from that point on. Such a discussion would supplement and clarify any written material provided to the complainant about the SPSO's role and procedures.

INVESTIGATIVE FOCUS

13. The complaint and its jurisdictional complications did not receive proper attention until some eleven months after it had been received. Even then, there was no consideration of injustice, a key question presumably in deciding whether or not this was a complaint serious enough for the SPSO to pursue.
14. There were numerous file notes and an investigative plan showing that consideration had been given to the substance of the complaint. But there was a lack of incisiveness and a reluctance to make decisions about the scope of the investigation, whether certain elements of the complaint were in jurisdiction or not, just what questions needed to be asked of the Council, which Council officers needed to be interviewed, and whether enquiries should be made of the complainant's husband's employers (his career prospects, even job security, had allegedly been put at risk by actions of the Council, or by Council Members and officers acting inappropriately). As a result, further delays and confusion drifted into the process. I note at one point that the Council had to ask just what allegations were being investigated and its confusion was understandable.
15. A more incisive investigative focus could also have led to the SPSO sharing its concerns about the Council's complaint-handling arrangements for schools at a far earlier stage than was in fact the case. Had it done so, a quicker resolution of a substantial part of the complaint might well have been achieved, with the Council undertaking to review its complaints procedure in this area and to inject some independence into the process.

MANAGEMENT

16. There was a total absence of management involvement in this case until delays had become so gross that the situation was almost irrecoverable. Management intervention only occurred at crisis point, some fourteen months after the SPSO had received the complaint.

17. Clearly, mechanisms should have been in place to identify and correct the delays in investigating this complaint. I would have expected management information to monitor individuals' caseloads and how they are being progressed, and for managers to discuss on a regular, and if necessary frequent, basis the progression of difficult complaints with investigators. Such discussions would also, I feel, have helped sharpen the investigative focus.
18. The sort of checks I would expect to have seen include: a monthly printout to the local manager showing team performance figures in respect of numbers of decisions and time taken; a list of each investigator's cases showing the date of last actions on every complaint; a mechanism to ensure that every file of more than a certain age is shown to a senior manager or the Ombudsman with a note explaining why the file had taken such time and what action was now proposed (I see all files in my office at 40 weeks for instance); and regular discussions between a senior manager and the local manager concerning progression of cases over a certain age (in my office, all cases over 52 weeks).

COMMUNICATIONS WITH STAKEHOLDERS

The complainant

19. Early communications between the SPSO and the complainant were entirely inappropriate. The inordinate early delay in handling the complaint was on a number of occasions excused to the complainant by pressure of work within the office or the difficulties caused by annual leave. Problems of that nature should have been resolved by SPSO. It all must have left the complainant feeling frustrated, helpless and very angry. I am not surprised that she sought the assistance of her MSP in seeking to get some action from the office of the SPSO.

The Council

20. I have already referred above to the delay in bringing the complaint to the Council's attention, the unfocused enquiries made of it, and the resulting confusion over just what was being investigated. There were further problems caused later by the SPSO's change of mind over the criticisms it was making

of the Council's complaints procedure that, again, a more focused approach to the investigation should have avoided.

The MSP

21. The complainant sought the assistance of her MSP in her dealings with the SPSO some nine months after submitting her complaint. From that time on the MSP was very closely involved with the SPSO's investigation, meeting a number of times with the SPSO and her staff, and making frequent interventions by email and letter along the way. He was also intervening with the complainant's husband's employer, occasionally relaying information to the SPSO that he had gained in those dealings. At one point he felt able to alert the SPSO to an impending raid on her offices that the police were allegedly planning to secure information held by the SPSO in respect of one of their officers.
22. The intimate involvement of the MSP in the SPSO's ongoing investigation was, to me, one of the most surprising elements in the way this case was handled. That may, of course, just be a mark of the different cultures in which the SPSO and LGO operate. But on reflection I consider it to be one of the most worrying elements too.
23. The SPSO is, and must be seen to be, independent. He is independent of both complainant and the body complained against. In reaching his decisions that independence extends to all parties including parliament. He is an Officer of Parliament but parliament cannot tell him what decision to make in respect of complaints or allegations brought to him. If that is the case in respect of parliament, it is even more strongly so when dealing with Members of Parliament: the SPSO is an Officer of Parliament but he must be careful not to allow himself to become the flunkey of parliamentarians.
24. The responsibility for defining the relationship here rests squarely with the SPSO. MSPs will carry out their duties to the public and constituents as they best see fit, and it seems to me that this is what the MSP sought to do in this instance. But it is for the SPSO to define what is an appropriate relationship and to prevent any overstepping of the mark.
25. I have no doubt the mark was overstepped here. Perhaps because things had gone so badly wrong from the outset, the office of the SPSO may have given more leeway to the MSP in taking an influential role in the investigation than would otherwise be the case. But for whatever reason, the MSP's role was far

too influential. At times the SPSO sought information from the MSP about the complainant's husband's employer that the SPSO should have sought itself; it appeared to welcome information (or allegations) provided by the MSP in respect of the school involved in the complaint that was irrelevant to its investigation; in doing so, it appeared to indulge an agenda in respect of the school and members of the Council that was the MSP's own, and which was not material to the complaint in the SPSO's jurisdiction. This should have been the SPSO's investigation and not the MSP's. At times I could not tell the difference. The implications of this confusion of roles for the body under investigation need hardly be stressed. And nor need the dangers for the independence of the office of the SPSO.

REPORTING

26. It took some 23 months for a draft report to be produced and then a further ten months for the draft to be approved and issued to the complainant and the Council. That was far too long. It was not helped by confusion over who in the office of the SPSO should be involved in approving the draft.
27. After the first draft, it took a further eleven months and a second draft before a final report was published. But by this stage matters had become so complex that it was difficult to retrieve anything sensible, and it became a matter of wonder that a report should finally be issued at all.

Conclusions

28. The SPSO's handling of complaint 200502514 may have been uniquely unsatisfactory. But I conclude that it is likely, nonetheless, to point to some weaknesses in the workings of the office that may have systemic implications. I hope that in drawing out some potential lessons here the SPSO's review will be able to satisfy itself that these matters have been properly addressed for the future.

Jerry White

Local Government Ombudsman

29 September 2009

APPENDIX 2 CASE-HANDLING, KEY MILESTONES

Date	Action	Month
8 Dec 2005	Complaint received and acknowledged	0
11 Aug 2006	First contact from MSP	9
23 Feb 2007	Council told SPSO has received a complaint to be investigated	14
22 March 2007	Enquiries made of Council	15
22 Aug 2007	Interviews with Council officers	20
11 Oct 2007	Enquiries made of Strathclyde Police	22
28 Nov 2007	Draft Report prepared for Ombudsman	23
14 July 2008	Further enquiries of the Council	31
11 Sept 2008	Draft report sent to Mrs C (and probably to the Council)	33
8 & 9 May 2009	Second draft report sent to Mrs C and to the Council	42
19 Aug 2009	Report issued	45