

51. Another possibility is that a series of minor failings mean that on balance we make a finding of service failure.

**Did it lead to an unremedied injustice or hardship? (What was the impact of the maladministration/service failure on the people involved: the complainant and/or the aggrieved?)**

52. Where we find maladministration or service failure we then need to decide whether it led to an injustice. An error may have happened that did not lead to an injustice or someone could have suffered an injustice but it did not actually happen because of the maladministration or service failure. There are some cases in which it can never be known (even on the balance of probabilities) if there is a link between what went wrong and the claimed injustice (for example, some cases which revolve around the outcome of court proceedings had circumstances been different) and there are other cases where we will find that the link between maladministration and the claimed injustice is not established.
53. The impact and injustice are part of our findings. This is not just what the complainant/aggrieved says. We need to analyse the evidence and come to a finding. The key question is 'did the injustice claimed occur in consequence of the maladministration/service failure we have found' (not other things that may or may not have gone wrong). In health cases we are often guided on this by our clinical advisers, for example in relation to chances of survival, or impact of delay in treatment.
54. We can make findings of injustice which relate to the claimed injustice. For example we may find that death was not avoidable but that there was a missed opportunity to provide treatment which may have prolonged life. This has left the complainant in a position where they will never know whether, had that opportunity not been missed, the person would have survived and this has caused an injustice.
55. We cannot invent injustice. If we think that an injustice flows from the maladministration/service failure but the complainant has not raised this with us, we can ask them if they want us to consider it during our investigation.
56. Injustice could include:
- loss through actual costs incurred. For example care fees, private healthcare and loss of benefits;
  - other financial loss. For example, loss of a financial or physical asset (such as loss or damage to possessions), reduction in an asset's value, and loss of financial opportunity;

- being denied an opportunity. For example, to make a choice in the light of the full facts or risks (such as an informed consent decision in relation to a surgical procedure); and
- inconvenience and distress as a result of failures in service provision (for example, delay in receiving a benefit, worry over the effect of misinformation, cancelled operations, misdiagnosis) or where the handling of the complaint in itself has been prolonged or inadequate.

57. The [typology of injustice](#) contains definitions of the injustice types that have been identified from our casework.

58. If the injustice did happen because of the maladministration or service failure then we need to look at whether the injustice is still unremedied because, in some cases, the organisation complained about may have provided an appropriate remedy.

### **What can the organisation do to remedy any injustice or hardship?**

#### **Remedy for the individual and those similarly affected**

59. The Principles for Remedy are our guide in our approach to securing remedy for injustice which we have found to flow from maladministration/service failure we have identified. As the Principles say, some remedies are straightforward and others require very careful consideration. A key point is that remedy should be appropriate and proportionate to the injustice sustained. When an injustice is unremedied, our general approach is that we seek to place people back in the position they would have been in had the maladministration or poor service not occurred. The Principles say that where the injustice cannot be put right compensation may be appropriate. Most often this is where we recommend payments related to personal impact such as distress, frustration, pain and inconvenience. The Typology of Injustice and casework discussion helps us determine appropriate amounts by referring to our precedents and considering the circumstances of the individual case. Please note that remedies will be determined by the impact on the individual (or individuals) concerned

60. If an investigation has found maladministration or poor service and if we have found that an unremedied injustice flowed from that, then we will need to consider what type and level of remedy it is appropriate to pursue.

61. The types of remedy that we might seek to obtain will be tailored to the individual circumstances of the case (while taking account of similar cases). Appropriate remedies can include:

- apologies, explanations or acknowledging responsibility;

- remedial action such as reviewing or changing a decision; revising published material or revising procedures to prevent a recurrence; or
  - financial compensation.
62. Decide if redress is appropriate and, if so, identify a remedy which flows from, and is proportionate to, the injustice that has been identified. We need to be aware that it is for us to determine whether a remedy offered or proposed is appropriate, not the complainant.
63. Please note that an apology should always be by personal communication from a suitably senior person within the organisation in jurisdiction to the aggrieved or his or her representatives. The apology should be specific in what it is addressing rather than general. Expressions of regret and apology made through this Office rather than direct to the aggrieved are not an appropriate form of remedy.

#### **Specific considerations in respect of financial remedy**

64. Consider the following when looking at questions of financial remedy:
- Both the final amount that is paid and the way this amount is calculated should be proportionate to the injustice resulting from the maladministration.
  - Calculations of financial loss incurred by an individual should be based on evidenced and quantified loss. We may need to obtain an appropriate independent opinion, for example, legal or financial advice to check our understanding of the loss.
  - Any delay between when the financial loss was incurred and the compensation payment date should be recognised by the payment of appropriate interest.
  - Compensation should be appropriately linked to other forms of redress - for example, an apology.
  - Some organisations within jurisdiction may have their own compensation schemes by which they judge levels of financial remedy in respect of maladministration or poor service. In recommending a level of financial remedy we are not bound by the rules or limits of such schemes.
  - When considering the level of financial redress, we should also consider factors such as the impact on the complainant (were they

particularly vulnerable; was ill-health compounded, hardship aggravated or injustice prolonged?); the length of time taken to resolve the complaint and the trouble that the individual was put to in pursuing the complaint. When considering awards for distress or inconvenience we should also take into account the level of awards made to others who have suffered a similar injustice.

- Financial compensation may be appropriate, additionally, for injustice or hardship deriving from the pursuit of the complaint (as well as the original dispute). For example, costs in pursuing the complaint or additional inconvenience or distress caused.
- Is the outcome consistent with other cases we have looked at and any remedy proportionate to the injustice or hardship?

65. The [typology of injustice](#) contains a searchable database of a range of upheld or partly upheld investigations. This is intended to help caseworkers identify relevant precedent cases when thinking about recommendations for financial redress. Advice on proposed levels of recommendations for financial remedy can be sought from the [Outcomes and Compliance caseworker](#).

### **Escalation**

66. When reaching a decision on an investigation it is particularly important to think about whether any of the provisional findings suggest that there might be a wider systemic problem (outside of the individual complaint) either in relation to a particular issue (for example, are we seeing similar complaints about a range of health organisations) or a particular organisation (for example, are we seeing a range of similar complaints).

67. If the case has evidence of systemic issues then you should escalate the case to your Manager so that a decision can be taken on what action should be taken.

### **Systemic remedy**

68. We may also make recommendations for systemic remedy: to prevent a recurrence of the failings that we have found. Generally this should take the form of asking the body to propose their own solutions to the systemic problems we have identified in our report. Usually we do not make specific systemic recommendations. Our general approach is that it is for the individual or organisation to decide how to achieve the required changes and improvements. Most often systemic remedy is in the form of an action plan which asks the individual or organisation to set out what they will do and by when to address the failings identified in the report.

69. It may be appropriate to bring the need for a systemic remedy to the attention of the organisation at draft report stage with a view to opening a dialogue, which may also bring out the extent to which the body is aware of the problem and are taking/have taken steps to deal with it. It is not our role to direct the body as to the changes that they should make, although it is appropriate for us to guide the body if we consider that a specific form of remedy is merited.

### **Recommendations**

70. Recommendations in a report are used normally to obtain a remedy for injustice arising from maladministration or poor service. The basis for our recommendations is normally the unremedied injustice arising as a consequence of maladministration or service failure. In those circumstances, recommendations must be relevant to the injustice found: whether this is to the complainant concerned; to others who have been affected or to those who might be so affected in the future.
71. The remedy is to put right the injustice resulting from maladministration. It is not compensation for the maladministration.
72. All remedies must be SMART (specific, measurable, achievable and realistic, with a timescale).
73. Discuss the proposed or requested remedy with the complainant and manage their expectations if they are seeking a remedy that would be unachievable or disproportionate.

### **Payments where the aggrieved has died**

74. In cases where the aggrieved has died we will not automatically recommend that any financial remedy (which would have been payable to the aggrieved if they were alive) be paid to their family or to their estate. These cases should be considered on their individual merits, but the following should be considered:
- In cases of actual financial loss we can consider asking for payments that would have been due to the deceased to be made to their estate (for example, a special payment for loss of benefit that should have been paid while they were alive). However, we would need to be certain that any payment would have been payable to the deceased, were it not for the failings identified.
  - We would normally only recommend compensation for non-financial loss for the family members of the deceased if they have suffered a specific

injustice themselves (for example, emotional injustice as a result of witnessing the poor care given to their relative). This should be explored as part of the investigation.

### Compliance

75. When making recommendations we should also think about how the organisation under investigation will comply with them, what evidence we will need to see to satisfy ourselves that compliance has been achieved and how we will monitor compliance.

### When is an investigation upheld?

76. Where we have found that an unremedied injustice (or hardship) arose in consequence of maladministration or service failure then a complaint will be upheld (fully or partly as applicable). A decision about whether one of these cases is fully or partly upheld should be based on the circumstances of the case but a decision to partly uphold a complaint will normally result from a multi-strand complaint where we have only upheld some parts or a case where we found a lesser injustice than that claimed.

77. We will uphold (or partly uphold) complaints if we find that the injustice (or hardship) was remedied after the complaint was received by the Ombudsman but either before the start of, or during, an investigation. However, there may be some cases of this type where the organisation offers a full remedy and we do not make formal findings:

- If the full remedy is offered immediately in reply to the proposal to investigate. In these cases we may revert the case to an enquiry and close it as a resolution.
- The organisation offers a remedy during the investigation which is accepted by all parties and we close the case as a mediated outcome.

78. Where we have found that an injustice (or hardship) arose in consequence of maladministration or service failure but that it was fully remedied before the complaint was received by the Ombudsman then a complaint will not be upheld.

79. If we find that there was maladministration or service failure but that an injustice did not flow from it, then the complaint will be partly upheld. In some cases we may decide that, even though we have identified potential failings, the organisation should review the complaint and consider how it might be resolved.

80. A full list of investigation closure codes is at [Annex A](#).