Investigation of a complaint against the Western Health & Social Care Trust

Report Reference: 202004078

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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Listed Authority: Western Health & Social Care Trust

SUMMARY

This complaint was about care and treatment the Western Health & Social Care Trust (the Trust) provided to the patient. The patient has sought medical assistance since 2013 for a chronic, undiagnosed condition. The patient raised concerns about the Trust's failure to identify a root cause of her condition.

The investigation identified a failure in care and treatment. It found the Trust did not perform an MRI scan by an appropriate specialist to assist with diagnosis of the cause of the complainants ongoing symptoms between 2013 and September 2022 which were caused by deep endometriosis[1]. The failure identified led to a delay in diagnosis for the patient which meant she experienced prolonged chronic pain without an earlier opportunity for treatment.

The patient complained about the Trust's response to her complaint which contained significant 'medical jargon' without any effort to explain these in layman's terms. She also complained about inaccuracies in the Trust's response. The investigation found failures in complaint handling regarding the language the Trust used and the accuracy of its response. It therefore found maladministration in the Trust's handling of the complaint.
I recommended that the Trust apologise to the patient for the failings identified. I also recommended actions for the Trust to take to prevents future recurrence of the failings.

[1] Endometriosis is a medical condition where tissue similar to the uterine lining grows outside the uterus. This can cause pain, scarring and infertility

THE COMPLAINT

1. This complaint was about care and treatment the Western Health and Social Care Trust (the Trust) provided to the patient between 2013 and September 2022. It was also about whether the Trust appropriately handled the patient's complaint.

Background

2. The patient sought medical assistance from the Trust from 2013 for undiagnosed chronic pain. Her General Practitioner (GP) referred the patient to Gynaecology[2]. The Trust performed various examinations including Ultrasound Scans[3] (USS), Transvaginal Ultrasounds[4] (TVS) and laparoscopy[5]. The patient continued to feel unwell and attended numerous National Health Service (NHS) and private consultants during this time. Her GP referred the patient to Gynaecology again in July 2022 as an urgent referral. However, the Trust downgraded this referral to routine.

3. The patient submitted a summary of her health issues and her concern that the Trust could not identify the root cause of her issues on the forum, Care Opinion[6], on 16 July 2022. The Trust raised a complaint on behalf of the patient, with her consent, on 3 August 2022 regarding the issues the patient raised.

Issues of complaint

4. I accepted the following issues of complaint for investigation:

Issue 1: Whether the clinical investigations the Trust undertook for the patient between 2013 and September 2022 were appropriate and in accordance with guidance and relevant standards.

Issue 2: Whether the Trust's handling of the patient's complaint was appropriate and reasonable.

- **Whether the Trust addressed the patient's concerns fully and clearly.**
- **Whether the Trust's written response contained inaccuracies.**

[2] Gynaecology is the area of medicine that involves the treatment of women's diseases, especially those of the reproductive organs.
[3] An ultrasound scan is a procedure that uses high-frequency sound waves to create an image of part of the inside of the body.
[4] A transvaginal ultrasound is a type of pelvic ultrasound used by doctors to examine female reproductive organs.
[5] An examination of the abdominal organs using surgical methods to determine the reason of pain or other complications of the pelvic region or abdomen.
[6] Care Opinion is a feedback mechanism for health service bodies.

INVESTIGATION METHODOLOGY

5. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Trust complaints process.

Independent Professional Advice Sought

6. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisor (IPA):

   - A Gynaecology Consultant, MD, MFSRH, FRCOG, with 34 years experience in the field and a lead for endometriosis.

   I enclose the clinical advice received at Appendix three to this report.

7. The information and advice which informed the findings and conclusions are included within the body of this report. The IPAs provided 'advice'. However, how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

8. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional, and statutory guidance.

   The general standards are the Ombudsman's Principles[7]:

   - The Principles of Good Administration
   - The Principles of Good Complaints Handling

9. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

[7] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

The specific standards and guidance relevant to this complaint are:

- The General Medical Council's Good Medical Practice, updated in April 2014, and in April 2019 (the GMC Guidance);
- National Institute for Health and Care Excellence's Endometriosis: diagnosis and management, September 2017 (the NICE's Endometriosis guidance);
- Northern Ireland Direct's How to complain or raise concerns about health services, updated February 2024 (the NI Direct's Complaint guidance);
- Western Health and Social Care Trust's Complaints and Compliments Management Policy, updated September 2021 (the Trust's Complaints policy); and
- Department of Health and Social Care Complaints Procedure, updated April 2023 (DoH Complaint Procedure).

I enclose relevant sections of the guidance considered at Appendix four to this report.

10. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.

11. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. I gave careful consideration to the comments and obtained additional advice, before I finalised this report.

THE INVESTIGATION

Issue 1: Whether the clinical investigations the Trust undertook for the patient between 2013 and September 2022 were appropriate and in accordance with guidance and relevant standards.

Detail of Complaint

12. The patient raised the following concerns regarding care and treatment provided to her between 2013 and September 2022:

- The Trust was unable to diagnose the source of the patient's chronic pain despite performing several tests. This included findings later identified when the patient received treatment outside of the NHS.

- The Trust unnecessarily referred the patient to Gastroenterology[8].
- In April 2022, the Trust rejected an urgent GP referral to Gynaecology as it had already performed extensive tests in the past.

The patient said the above concerns impacted her mental health.

Evidence Considered

Legislation/Policies/Guidance

13. I considered the following [legislation/policies/guidance]:
    - The GMC guidance; and;
    - The NICE's Endometriosis guidance.

14. I enclose relevant sections of the guidance considered at Appendix four to this report.

The Trust's response to investigation enquiries

15. The Trust stated the patient had several appointments with the Gynaecology team over the past nine years and made attempts to diagnose and provide appropriate treatment for the patient.

16. The Trust stated it reviewed all radiology[9] imaging it carried out for the patient between December 2021 and February 2022. It did not identify any abnormalities.

17. The Trust wished to assure the patient that it transferred her to the relevant department when the Gynaecology team ruled out a gynaecological concern.

18. The Trust stated it did not add the patient to the waiting list for Gynaecology following a GP referral in April 2022. This was because it completed extensive investigations previously without identifying a gynaecological cause. There would be *'little benefit'* in repeating these examinations again with the patient.

[8] Gastroenterology is a specialized area of medicine that focuses on the digestive system and its disorders.
[9] Radiology is the field of medicine that uses imaging techniques (such as X-rays) to diagnose and treat diseases.

19. In its response to the draft report, the Trust said during the laparoscopy, carried out on 22 October 2013, *'a cystic lesion was noted in the pouch of Douglas. This was removed and histological examination demonstrated a multilocular peritoneal inclusion cyst or a benign mesothelioma'*. It further stated, *'this was not a rectal nodule'*.

20. The Trust did not agree it should have considered an endometriosis diagnosis and MRI/additional imagining for the patient during the period 2016 – 2021.

Relevant Trust's records

21. I considered records the Trust and patient provided. I enclose a chronology of the care and treatment the patient received at Appendix five to this report.

Relevant Independent Professional Advice

22. The IPA advised the Trust performed a laparoscopy examination on the patient in October 2013. The IPA initially indicated that the Trust should have *'acknowledged'* its finding of a rectal nodule[10] at that time. In updated advice following receipt of further evidence from the Trust the IPA confirmed that a rectal nodule was ruled out by the Trust through histological examination and what had been identified was a cyst which was removed.

23. In relation to the possible delay in diagnosis the IPA advised *'the* issue *here is one of being open to possibility of endometriosis given prevalent/past symptoms/signs, and one which will help the organisation and its agents to learn from any possible errors in care'.* The *'possibility of endometriosis including deep colorectal endometriosis should have nevertheless been considered'* and advised a further MRI should have been arranged due to the '*prevalent/past symptoms/signs'.*

24. The IPA advised the investigations the Trust performed between 2013 and 2016 were *'appropriate'*.

[10] A small swelling or aggregation of cells in the body in the anus.

25. The IPA advised the Trust completed an USS on the patient in November 2016 and December 2021. However, the patient experienced *'intractable pain'*[11], and the Trust should also have performed '[*Magnetic resonance imaging*] (*MRI*)'[12].

26. In response to the Trust's comments, the IPA advised, *'The diagnosis of endometriosis was considered in so far that it was excluded and patient referred to other specialists. Given the previous laparoscopy findings, even considering what was done, it has to be accepted that there was a level of uncertainty and therefore any reasonable specialist in endometriosis should have been arranging additional imaging including MRI'.*

27. The IPA further advised for the period of 2016 – 2021, there had *'been an overreliance on previous laparoscopy and interim MRI and USS findings*. *A repeat MRI and/or laparoscopy should have been requested and given that endometriosis is a progressive disease, it would have resulted in early diagnosis and treatment. Instead, patient was referred to other specialists, but this approach had been undertaken before as well without success'*

28. The IPA advised that not completing appropriate tests on the patient would *'delay the diagnosis of endometriosis'*[13]. In turn, this may have led to '*earlier diagnosis'* and surgical treatment. This may have *'relieved [the patient's] pain by 50%'*.

29. The IPA suggested learning that related to identifying the *'symptoms of endometriosis'* and the *'need for repeat investigations and/or laparoscopy in case of intractable pain symptoms'*. The IPA advised *'negative imaging findings do not rule out endometriosis'*.

30. The IPA summarised in his further advice, *'this case is a good example of exactly why and unless Trusts acknowledge that more can and should be done, improvements in managing this condition will be limited'.*

[11] Pain hard to control or deal with.

[12] MRI is a non-invasive medical imaging test that produces detailed images of almost every internal structure in the human body.

[13] Endometriosis is a medical condition where tissue similar to the uterine lining grows outside the uterus. This can cause pain, scarring and infertility.

Analysis and Findings

31. The patient was concerned that despite the clinical investigations the Trust undertook between 2013 and September 2022 it did not identify the source of her pain.

32. Section 1.1.3 of the NICE's Endometriosis guidance states that Gynaecology services for women with suspected or confirmed endometriosis should have access to a gynaecologist with expertise in diagnosing and managing endometriosis.

33. Section 1.3.1 of the NICE's Endometriosis guidance encourages doctors to *'suspect endometriosis in women'* when the patient is presenting *'chronic pelvic pain'* and/or *'gastrointestinal symptoms'*. Having reviewed the patient's medical records, I note she frequently reported pelvic pain to both her GP and the Trust during the relevant period. On this basis, I accept the IPA's advice that the Trust should have considered endometriosis as a potential diagnosis for the patient.

34. I considered the investigations the Trust undertook between 2013 and 2022. The IPA advised that those the Trust undertook between 2013 and 2016 were reasonable and appropriate.

35. The patient's GP referred the patient to the Trust again in 2016. The Trust performed an ultrasound scan which did not identify any gynaecological cause for her pain. I refer to Section 1.5 of the NICE Endometriosis guidance. It states clinicians *'should not exclude the possibility of endometriosis if the abdominal or pelvic examination, ultrasound or MRI are normal'*. In addition, the IPA advised *'negative imaging findings do not rule out endometriosis'.*

36. I note the patient's records do not indicate that the Trust performed an MRI at this stage to enable it to reach a diagnosis. The NICE Endometriosis guidance does not recommend MRI as a primary diagnostic tool. However, it does recommend it if clinicians suspect the presence of deep endometriosis. The IPA advised that, given the patient experienced *'intractable pain'*, it would have been appropriate for the Trust to perform an MRI at that stage. The IPA considered this a *'missed opportunity'* for the Trust. I accept this advice.

37. I consider the Trust's decision not to perform an MRI for the patient in 2016 a failure in her care and treatment. I uphold this element of the complaint. The IPA advised that not completing the appropriate tests on the patient would have delayed a diagnosis of endometriosis. It also would have allowed for appropriate surgical treatment that *'would have relieved pain by 50%'*. I will further consider the injustice to the patient later in this report.

38. I refer to the patient's complaint about the Trust referring her to the Gastrointestinal Department to rule out potential bowel disease. Following no evidence of bowel disease, the Trust referred the patient back to Gynaecology in April 2014. In accordance with Section 1.5 of the NICE's Endometriosis guidance, *'if clinical suspicion remains or symptoms persist, consider referral for further assessment and investigation'*. I also note the IPA's advice that the decision to refer the patient for gastrointestinal investigations was appropriate. I accept his advice. In the complainant's response to the draft report, she disagreed with the IPA's advice but did not provide any additional evidence for me to consider.

39. I consider it was important that the Trust conducted appropriate investigations with the patient to rule out a potential gastrointestinal condition. I consider in doing so, the Trust acted in accordance with the GMC requirement for the *'investigation or treatment you propose, provide or arrange must be based on this assessment, and on your clinical judgement'*. Based on the evidence available, I do not uphold this element of the complaint.

40. I refer to the patient's complaint about the Trust's decision to reject an urgent GP referral in April 2022 for a *'gynae work up'*. The patient said the Trust rejected it because it had performed extensive tests in the past.

41. In the Trust's response to this Office, it stated it would not add the patient to the waiting list as '*there would be little benefit in repeating these again'* as these previous '*extensive investigations'* had found *'no Gynaecological cause'* for her pain. I also note the referral was not specifically for a MRI but for a *'gynae work up'*

42. However, in respect of this referral, I note the IPA's advice that, although the Trust did not undertake an earlier MRI in 2016, it was still reasonable for it to not consider the referral in April 2022 as urgent after it reviewed the numerous investigations, it had previously carried out and still considered to be appropriate at the time of the *'gynae work up'* referral. The Trust also communicated this effectively to the complainant's GP at the time. I accept this advice and therefore do not uphold this element of the complaint.

43. In summary, I partially uphold this issue of complaint. I found the majority of the care and treatment the Trust provided during the period 2013 to 2016 was reasonable and appropriate. However, I consider that in 2016 the Trust failed to appropriately consider her intractable pain and her *'prevalent/past symptoms/signs'*, should have prompted an MRI scan. The Trust failed to carry out this test which would have been appropriate and would have allowed much earlier diagnosis and treatment of the patient's endometriosis. I found this a failure in care and treatment.

44. I appreciate how difficult it was for the patient to live with chronic pain for the period of nine years without a diagnosis. I consider these failures caused the patient to sustain the injustice of uncertainty and distress regarding her chronic pain. The patient also experienced the loss of opportunity for earlier diagnosis and appropriate treatment to relieve the significant pain she was experiencing.

45. I acknowledge that as part of the internal complaints process the Trust offered the patient a further TVS on 21 September 2022. I appreciate this step the Trust took to try and resolve the patient's concerns and consider it was appropriate that it should have done this as a minimum.

Issue 2: Whether the Trust's handling of the patient's complaint was appropriate and reasonable.

- **Whether the Trust addressed the patient's concerns fully and clearly.**
- **Whether the Trust's written response contained inaccuracies.**

Detail of Complaint

46. The patient raised the following concerns regarding the Trust's handling of the complaint:
    - The Trust failed to address her concerns adequately, as the response contained 'medical jargon' and did not explain its actions.
    - The final response to the complaint contained inaccuracies.

Evidence Considered

Legislation/Policies/Guidance

47. I considered the following policies and guidance:
    - The Trust's Complaints policy; and
    - DoH's Complaint Procedure.

The Trust's response to investigation enquiries

48. The Trust stated it issued its final response to the patient on 31 October 2022. It endeavoured to answer all issues raised in the complaint.

Relevant Trust's records

49. I considered the complaint records the Trust and patient provided. I enclose a chronology of the complaint correspondence received at Appendix five to this report.

Analysis and Findings

50. The patient said the Trust did not address her concerns fully and clearly, as it used medical terminology and did not explain the actions taken.

51. I note the Trust's written response letter contains numerous medical terms throughout. The DoH's Complaint Procedure states the response should be 'easy to understand' and avoid technical terms. Where these must be used to describe a situation, events or condition; the Trust should provide an explanation of the term. The DoH's Complaint Procedure also states that in such a situation, Trusts should refer the patient to a member of its staff to clarify any aspect of the letter.

52. Having reviewed the letter, I am satisfied the Trust took steps to address each of the concerns the patient raised. However, I note it contained a significant amount of 'medical jargon' and did not contain any explanations that would have assisted the patient in her understanding of it. It also does not refer the patient to a named member of its staff for her to contact. I consider this was not in accordance with the DoH Complaint Procedure.

53. The patient was also concerned that the Trust's letter contained inaccuracies. I note the letter states the referral to Gynaecology in April 2022 was downgraded from urgent to routine. However, the Trust's response to this Office stated it did not add the patient to the waiting list as it had already completed extensive investigations. I find this to be a significant factual inaccuracy in the Trust's response to the patient, which was unacceptable. I consider the Trust should have clearly and accurately explained to the patient in its response how it had handled this referral. Section 3.44 of the DoH Complaint Procedure requires a response to a complaint to be *'clear'* and *'accurate'*. I find the Trust failed to act in accordance with this standard in this respect.

54. The First Principle of Good Complaint Handling requires bodies to act in accordance with relevant guidance. The Second Principle of Good Complaint Handling requires bodies to ensure they *'use language that is easy to understand'*. The Third Principle of Good Complaint Handling requires bodies to be 'open and accountable', which includes being accurate in its responses. I am satisfied the Trust did not act in accordance with these principles when it responded to the patient's complaint. I consider this constitutes maladministration and I uphold this element of the complaint. I am satisfied this failure caused the patient to sustain the injustice of frustration.

55. I would ask the Trust to be mindful of the language it uses when providing complainants with medical explanations of their conditions. It should bear in mind that patients do not have the level of medical expertise that clinicians who provide responses do. Therefore, it is essential when responding to any complaint that the recipient of the response will be able to fully understand the explanation offered by the Trust, otherwise there is no resolution or reassurance for the complainant through the complaints process.

CONCLUSION

56. I received a complaint about clinical investigations the Trust undertook for the patient between 2013 and September 2022. I upheld elements of the complaint for the reasons outlined in this report. I am satisfied each element upheld represents a failure in care and treatment.

57. I also identified maladministration in how the Trust responded to the patient's subsequent complaint.

58. I recognise the failures caused the patient to sustain the injustice of a loss of opportunity, uncertainty, distress and frustration. I am also satisfied that the failure to give an earlier diagnosis caused the complainant to endure prolonged pain. I was sorry to hear about the patient's difficulties with her attempts to identify the root cause of her pain. In her complaint to my office, the complainant clearly articulated the impact that living with this pain has had on her. I hope this report and the recommendations outlined below go some way to address her concerns.

Recommendations

59. I recommend the Trust provides to the patient a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustice caused as a result of the maladministration identified (within one month of the date of this report).

60. I also recommend, for service improvement and to prevent future reoccurrence, that the Trust:

    i. Shares this report with relevant staff involved in the patient's care as part of their appraisal process and for future development and understanding;

    ii. Provides training to relevant staff to include:

    - The importance of conducting appropriate investigations in accordance with NICE Endometriosis guidance and GMC Standards;
    - The importance of sharing relevant patient information with those clinicians involved in their care, in accordance with GMC Standards; and
    - The importance of avoiding the use of medical jargon when responding to complaint submissions.

61. I recommend the Trust implements an action plan to incorporate these recommendations and should provide me with an update within three months of the date of my final report. The Trust should support its action plan with evidence to confirm it took appropriate action (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff read and understood any related policies).

62. I note the Trust did not accept my findings and recommendations. I fully considered its comments in response to a draft version of this report and sought additional independent professional advice. However, based on the evidence available and advice received, I have not changed my findings outlined above.

SEAN MARTIN
Deputy Ombudsman **June 2025**

Appendix 1 - PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances.
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.

- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

Appendix 2 - PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learned from complaints.
- Including complaint management as an integral part of service design.
- Ensuring staff are equipped and empowered to act decisively to resolve complaints.
- Focusing the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure in the right way and at the right time.

2. Being customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including where appropriate co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

3. Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.

- Providing honest evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

4. Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions and actions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

6. Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and the changes made to services, guidance or policy.