Appendix 1

Local Government & Social Care OMBUDSMAN

Report by the Local Government and Social Care Ombudsman

Investigation into a complaint against London Borough of Barking & Dagenham (reference number: 18 018 324)

15 January 2021

The Ombudsman's role

For more than 40 years the Ombudsman has independently and impartially investigated complaints. We effectively resolve disputes about councils and other bodies in our jurisdiction by recommending redress which is proportionate, appropriate and reasonable based on all the facts of the complaint. Our service is free of charge.

Each case which comes to the Ombudsman is different and we take the individual needs and circumstances of the person complaining to us into account when we make recommendations to remedy injustice caused by fault.

We have no legal power to force councils to follow our recommendations, but they almost always do. Some of the things we might ask a council to do are:

- apologise
- pay a financial remedy
- improve its procedures so similar problems don't happen again.

Section 30 of the 1974 Local Government Act says that a report should not normally name or identify any person. The people involved in this complaint are referred to by a letter or job role.

Key to names used

Mrs D	The complainant

Report summary

Environmental Services & Public Protection & Regulation

Mrs D complains the Council failed to take appropriate action after she raised concerns of a cancer cluster in her neighbourhood.

Finding

Fault found causing injustice and recommendations made.

Recommendations

We recommend that, within three months of the date of this report, the Council should:

- provide the personal remedy it has offered Mrs D, which is to:
  - investigate her reports of a cancer cluster;
  - pay her £750 to recognise the distress, uncertainty and confusion its faults have caused her.
- develop a procedure detailing its expectations for teams dealing with reports of non-infectious disease clusters. The procedure should:
  - be written to run alongside Guidance issued by Public Health England;
  - ensure there is no 'wrong door' to reports of this kind;
  - note the need for careful record keeping.
- consider how it can use this report and the new procedure, to raise internal awareness of its public health duties; and
- consider the report and confirm within three months the action it has taken or proposes to take. The Council should consider the report at its full Council, Cabinet or other appropriately delegated committee of elected members and we will require evidence of this. ***(Local Government Act 1974, section 31(2), as amended)***

The Council has accepted our recommendations.

The complaint

1. The complainant, whom we shall refer to as Mrs D, complains that:
   - the Council did not respond to her reports of a cancer cluster in her neighbourhood;
   - over a few months she chased a response to her first contact, but did not receive one;
   - after not receiving a response to her contacts, she complained. But the Council only provided a stage two response after she complained to us; and
   - the stage two response wrongly signposted her to the Environment Agency.

Legal and administrative background

The Ombudsman's role and powers

2. We investigate complaints about 'maladministration' and 'service failure'. In this report, we have used the word 'fault' to refer to these. We must also consider whether any fault has had an adverse impact on the person making the complaint. We refer to this as 'injustice'. If there has been fault which has caused an injustice, we may suggest a remedy. ***(Local Government Act 1974, sections 26(1) and 26A(1), as amended)***

Local authority public health duties

3. The Health and Social Care Act 2012 gave upper tier and unitary authorities new responsibilities to improve the health of their populations. This built on existing public health duties. It also introduced the role of Director of Public Health (DPH), who are the lead officers for health in local authorities.

4. One of the public health duties of local authorities, such as the Council, is the responsibility, led by their DPH, to investigate reports of non-infectious disease clusters.

Public Health England's *Guidance for investigating non-infectious disease clusters from potential environmental causes*

5. The stated aim of Public Health England's (PHE) Guidance is to help local authorities and local public health authorities investigate reports of non-infectious disease clusters. It recommends a systematic, integrated, staged approach for responding to reports.

6. The Guidance recommends:
   - the first step is to screen the enquiry. This includes gathering information from the enquirer;
   - an investigation should have three tracks (health, exposure and communication), progressed in parallel;
   - a follow up telephone contact with the enquirer should be arranged;
   - a written response should follow at the end of an investigation; and
   - the DPH should end their investigation if they conclude that the cluster is not of public health importance.

How we considered this complaint

7. We produced this report after examining relevant documents and speaking to the complainant.

8. We gave the complainant and the Council a confidential draft of this report and invited their comments. The comments received were taken into account before the report was finalised.

What we found

What happened

9. Mrs D lives in a residential neighbourhood in the Borough. In April 2018 she made five requests to the Council (one from her and the rest on behalf of neighbours), about a cluster of cancer cases in their area. She asked for an investigation into a possible link. The Council says a 'system error' meant it did not deal with these requests in the usual way.

10. Mrs D telephoned the Council at the end of April asking what action it planned to take. In response to our enquiries, the Council says its Contact Centre passed the enquiries to its Health and Safety Team and closed the case. It has no records of this action.

11. In July, Mrs D again telephoned the Council, as she had not heard anything. The Council's officer sought to find out who to refer the enquiry to. The Council says its Customer Resolution Team usually ensures either it or the relevant team calls the enquirer back. But its stage one complaint response accepted it did not call Mrs D back. It apologised.

12. Although the Customer Resolution Team has not kept any records, it seems it sent Mrs D's July contact to the Council's environmental protection inbox. An Environmental Health Officer saw this email. He checked that team's records and concluded there was no record to suggest land contamination in the area where Mrs D lives. He sent an email to another officer advising it was a public health matter. However the Council says '…this was not passed on to the Director of Public Health in a timely way.'

13. In October, as she had not heard anything, Mrs D complained. The Council's November stage one complaint response advised Mrs D her first contact did not reach its Health and Safety Team due to an administrative error. And it did not deal with her follow up contacts correctly, due to the original error. It recognised it should have identified these errors. It apologised.

14. The Council says its complaints team did not monitor whether its Environmental Health team provided Mrs D with a follow up response, as it expected would happen. Instead it closed the complaint.

15. In November the Council's Environmental Health team sent a report to its Director of Public Health with a covering email. The email advised the DPH of Mrs D's contact and its research about land contamination. In response to our enquiries, the DPH says he did not take any further action, as none was requested.

16. The DPH says he remembers the Director with responsibility for the Environmental Health team contacted him a couple of weeks later. He suggested the DPH could carry out a small study into Mrs D's reports. The Council has not sent me any record of this discussion, made at the time. No part of the Council took any further action about the suggested study.

17. In December 2018, Mrs D asked the Council to escalate her complaint. In March 2019, Mrs D complained to us, as she had not heard from the Council. We asked it to provide Mrs D with a stage two response. The Council says the lack of records hampered the response, which it did not complete until June. In the stage two response it advised Mrs D:

- '…due to the unusual nature of your request, Contact Centre staff did not know who to route the enquiry to'; and
- '…the Council is not able to assist with your enquiry or able to open an investigation into the quality of the air. We would recommend that this is best directed to the Environment Agency.'

18. Mrs D contacted the Environment Agency who advised it did not deal with the matters she had raised. It referred her to the Council's 'Health and Safety department'.

19. Mrs D complained again to us. Our enquiries were delayed by a pause in our casework due to the COVID-19 pandemic. After we could make enquiries, the Council responded to advise us of the following.

- Its Contact Centre did not have any procedure to follow when receiving enquiries like Mrs D's.
- It accepted it was expected to follow PHE's Guidance.
- It had not developed a procedure to use alongside the Guidance.
- 'We now know a different approach should have been taken from the start. We accept the case was not given the level of attention it required, and communication continued to be a problem at all levels. Information was not shared with a wide enough audience from July 2018 onwards and medical evidence was not collected in the way the policy requires. The lack of oversight, failure to record key decisions and provide Mrs [D] with regular updates, caused undue stress during a period of recovery.'
- 'We accept officers failed to collect information about risks and health in parallel, determine if a link exists, and then communicate this to the parties affected.'
- 'To prevent a similar problem arising in the future, we plan to issue front line staff with guidance that sets out the role each service plays from inception to making decisions, and the timescales involved.'
- It proposed to write to Mrs D to gather information in a way it accepted it should have done earlier.
- It accepted it could have done more in 2018 and 2019 to allay Mrs D's fears. It missed the opportunity to put that right when she complained. To remedy the undue distress, uncertainty and confusion, it advised it would like to make a payment to Mrs D of £750.

Analysis

20. The Council has important public health duties; often, as here, led by its DPH. We are concerned from the evidence seen there is a lack of understanding in the Council of its DPH's duties to investigate reports of possible non-infectious disease clusters.

21. After some delay, the complaint was passed to the DPH's office. But no plan was agreed and no team took ownership of the issue.

22. Mrs D's two-stage complaint did not resolve these faults, as it should have done. It took six months from Mrs D's request to escalate her complaint, for the Council to provide a stage two complaint response.

23. It was only in response to our enquiries that the Council provided a response that referenced the PHE Guidance. It was only then, over a year after Mrs D's enquiry, that it proposed an action plan. At this stage it recognised its fault and the injustice this would have caused Mrs D. It proposed a personal remedy for Mrs D. It also proposed action to prevent a recurrence of the faults raised by this complaint.

Conclusions

24. We uphold each of Mrs D's complaints.

- The Council did not respond to her enquiries, as it should have done. It did not follow PHE's Guidance.
- The Council did not resolve the matter when Mrs D chased a response. It delayed referring the matter to its DPH.
- When the Council did make a referral to its DPH, neither his team nor the referrer progressed an investigation.
- The Council's complaint responses did not resolve the matter.
- Mrs D had to complain to us before the Council provided its stage two complaint response.
- The stage two response incorrectly referred Mrs D to the Environment Agency.

Recommendations

25. The Council must consider the report and confirm within three months it has taken the agreed actions. The Council should also consider the report at its full Council, Cabinet or other appropriately delegated committee of elected members and we will require evidence of this. ***(Local Government Act 1974, section 31(2), as amended)***

26. We welcome that, in response to our enquiries, the Council proposed action to remedy the injustice it had identified. The Council should be commended on that response. Our view is its offer of a personal remedy to Mrs D is an appropriate response to the injustice the faults caused.

27. We recommended that, within three months of the date of this report, the Council should:

- provide the personal remedy it has offered Mrs D, which is to:
    - investigate her reports of a cancer cluster;
    - pay her £750 to recognise the distress, uncertainty and confusion its faults have caused her.
- develop a procedure detailing its expectations for teams dealing with reports of non-infectious disease clusters. The procedure should:
    - be written for its use to run alongside Guidance issued by Public Health England;
    - ensure there is no 'wrong door' to reports of this kind;

- note the need for careful record keeping.

- consider how it can use this report and the new procedure, to raise internal awareness of its public health duties.

28. The Council has accepted our recommendations.

Decision

29. We uphold the complaint. The Council has agreed to our recommendations so we have completed our investigation.