Northern Ireland
Public Services
Ombudsman



2018 | 2019

Ombudsman's Report

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REPORT

of the

Northern Ireland Public Services Ombudsman

2018-19

Presented to the Assembly pursuant to section 46 (1) of the Public Services Ombudsman Act (Northern Ireland) 2016.

Contents

Foreword from the Ombudsman

I am pleased to present this, my third and final general report as Northern Ireland Public Services Ombudsman. The Public Services Ombudsman Act (NI) 2016 (the 2016 Act) abolished the former offices of Assembly Ombudsman for Northern Ireland and Northern Ireland Commissioner for Complaints and created a single ombudsman's office for complaints about devolved public services. The Act requires me to lay this report before the Northern Ireland Assembly[1].

The report highlights, for the third year in a row, an increase in the number of complaints being dealt with by my Office. In 2018-19 we received 762 new complaints, an increase of 15% from 2017-18. This also represents a substantial increase of 60% from the number of complaints received in 2015-16.

As Public Services Ombudsman my role is to investigate complaints of maladministration about public service providers. Maladministration is not defined in the 2016 Act but it can include the wrong application of rules and a failure to follow policies or procedures. I also investigate complaints about professional judgment in health and social care.

Members of the public must exhaust the internal complaints process of the relevant service provider before complaining to my Office. It is important to ensure that complainants and those bodies and individuals that are the subject of a complaint are dealt with fairly, impartially and consistently by my staff.

As this is my final report I believe now is an appropriate time to reflect on the progress that has been made over the last three years.

Three years of new powers

In 2016, my jurisdiction as Ombudsman was extended to include complaints about the Northern Ireland Audit Office, the Assembly Commission, and all universities and colleges in Northern Ireland. On 1 April 2017, complaints about all publicly funded schools in Northern Ireland were also included in my remit.

As a result of these legislative changes I am able to investigate complaints across the education sector in Northern Ireland. This includes complaints about the Department of Education, the Education and Training Inspectorate, CCEA, CCMS as well as nursery schools and all publicly funded schools in the primary and secondary sector, as well as colleges and universities.

In January 2019 I became the first UK public services Ombudsman to use 'own initiative' powers when I issued a proposal to launch an investigation into the administering of Personal Independence Payments by the Department for Communities.

1 An Annual Report and Accounts for 2018-19 is available separately

In October 2018 I hosted an international conference on the theme of 'own initiative' investigations.

This new power allows me to investigate where I have a reasonable suspicion of systemic maladministration or systemic injustice (in health and social care), even if no complaint has been made to my Office.

I also now publish my investigation reports where, having taken into account the views of the complainant and service provider, I believe it is in the public interest to do so. A total of 27 investigation reports were published on my website during 2018-19. Case summaries of a number of these investigations can be found in Section 4 of this Report.

Part 3 of the 2016 Act provides for the establishment of my Office as the Complaints Standards Authority (CSA) of Northern Ireland, requiring the Ombudsman to develop and consult on a set of complaint handling principles for public bodies. In preparation for this power my staff have conducted research into complaints handling procedures across the public sector in Northern Ireland. This is in anticipation of a restored Assembly formally commencing the CSA powers.

My Office continues to receive a high proportion of complaints which could have been resolved by the public service provider locally, meaning that people are left waiting longer than necessary for answers and that much needed service improvements are delayed.

This new function will enable the Office to work with public service providers to provide consistency in complaints handling across the public sector.

Once commenced this function is likely to have a significant positive impact on the relationship between members of the public and public service providers.

Health and Social Care complaints

This report demonstrates the broad range of complaints dealt with by my Office. These relate to housing, education, and the full range of services provided by central and local government.

As can be seen from the statistics in Section 2 though, by far and away the largest proportion of complaints come in the field of health and social care. The issues in these cases relate to delays in care and treatment, misdiagnosis, poor communication with patients and their families, care and treatment in nursing homes, and complaints about eligibility for continuing healthcare.

I have also been engaged in work on the issue of patient involvement and openness in the health and social care system, and on the subject of Duty of Candour. This follows Mr Justice O'Hara's Hyponatraemia report of January 2018. During the year Mr Justice O'Hara visited my Office and spoke to my staff. It was clear that many of the themes he identified in his report are ones I see regularly in my investigations.

Poor Record Keeping

Poor record keeping emerged as a recurrent theme in the cases examined by Justice O'Hara. While often not an issue raised with me by complainants, poor record keeping by health and social care bodies remains an issue which is commonly identified during my investigations. The lack of attention by health care professionals in this area has the potential to have a significantly detrimental impact on patient care.

To emphasise the importance of this discipline, and to assist all staff who work within the public sector, my Office has begun working with the Information Commissioner's Office and the Northern Ireland Audit Office to produce a guide to Good Record Keeping later in 2019.

50th Anniversary

The Guide will be launched at an event to acknowledge that 2019 marks the 50th anniversary of the Ombudsman's Office in Northern Ireland. Legislation to create a Northern Ireland Ombudsman was passed in November 1969, following concerns over inequality in housing, employment and education.

The role of the Ombudsman in assessing complaints about alleged unfairness in public sector decision making is as important now as it was then.

Oversight and Regulation Forum for Northern Ireland

Given the absence of Assembly Committees to ensure adequate scrutiny of Government and its agencies, I have established the Oversight and Regulation Forum for Northern Ireland. The first meeting was held in June 2018 and brought together statutory office holders from the Audit Office, Information Commissioner's Office, Human Rights Commission, Equality Commission, Criminal Justice Inspectorate, the Children's and Older Persons Commissioners, RQIA and myself as Ombudsman.

At the first meeting we agreed the terms of reference of the group, and to annually share strategic work programmes so as to avoid overlap and duplication.

Scrutiny and accountability

The continued absence of a functioning Assembly gives me cause for concern. That is because as part of their scrutiny role Assembly Committees play a significant role in holding the Executive to account.

Under normal circumstances my investigation reports would be sent to a Committee of the Northern Ireland Assembly for their consideration and debate.

This would mean, for example, that if a report about a public body had drawn attention to maladministration and injustice, the Committee could then decide whether they wished to call officials to give evidence. In this way my counterparts in England, Scotland and Wales, and indeed internationally, all play their part in the democratic process.

Giving evidence to the Welsh Assembly

Currently the scrutiny processes provided for in the Northern Ireland Act 1998 are not working effectively, meaning that lessons learned from complaints are not being fully communicated.

Conclusion

In summary, the story of the last three years has been one of continuous change. Now that the majority of the powers have been drawn down, I am proud to say that Northern Ireland is able to boast a fit for purpose, forward thinking, modern Office capable of investigating complaints about public services.

I look back with pride on the achievements of the last three years. They are a testimony to the professionalism, dedication and hard work of all of my staff – qualities which I have benefitted from in my time as Public Services Ombudsman and which I know will be appreciated by my successor.

Marie Anderson

Ombudsman

Section One
ASSIST (Advice, Support Service and Initial Screening Team)

Of all the calls and enquiries received during 2018-19, a total of **762** were classed by the ASSIST Team as complaints warranting more detailed analysis. This was an increase in **15%** from the 2017-18 figure.

A total of **664** of these were decided on within ASSIST. The remainder, **98**, were passed to the Investigations Team for further investigation (see Section 3).

The Ombudsman looks at complaints of maladministration about public services in Northern Ireland.

The term 'maladministration' has never been defined in legislation, but is often taken to mean inefficient or dishonest application of the rules.

Some examples of maladministration include:

- Unfairness
- Avoidable delay
- Faulty procedures or failing to follow the correct procedures
- Not telling someone about any rights of appeal they have
- Bias or prejudice in decision making
- Giving misleading or inadequate advice
- Discourtesy and failure to apologise properly for errors
- Mistakes in complaint handling

The Ombudsman can also consider complaints about the professional judgment of health and social care professionals.

ASSIST plays an important role in providing advice and guidance to members of the public who want to pursue a complaint. Making a complaint is free, but importantly the Office does not investigate every complaint it receives.

There are three main stages to our case handling process:

- **Initial Assessment**
- **Assessment**
- **Investigation**

ASSIST deals with the first two stages, while the third is dealt with by the Investigation Team.

Initial Assessment

The ASSIST team look at every complaint to decide if the Ombudsman can investigate under the terms of the Public Services Ombudsman Act (Northern Ireland) 2016. Examples of where we would generally not investigate would include if a complaint was:

- Made without being first looked at by the relevant public body
- Made to the Ombudsman more than 6 months after completing the body's complaints procedure (unless the Ombudsman decides there are special circumstances)
- About private health care or private education
- The subject of civil or criminal proceedings
- The subject of an inquiry

Where ASSIST decides to take no further action, complainants receive a clear explanation as to how and why the decision was reached and, where useful, are provided with information about other potential sources of assistance.

It is important that members of the public receive an answer to their complaint as quickly as possible. In 2018-19 ASSIST issued a decision within 10 working days on **93%** of cases.

Assessment

If a complaint is referred for further assessment, the ASSIST team will obtain more information about the complaint. This may be from the complainant or the organisation concerned. The information will help them decide whether it appears, on the face of it, that there may have been maladministration.

At the Assessment stage the ASSIST team will see if they can resolve a complaint without it being referred for investigation. This process, which is similar to informal resolution or mediation, is known as a **Settlement**.

The team will speak to the complainant and the public body to see if a Settlement would be appropriate. This may take the form of an apology or acknowledgment that something has gone wrong, reimbursement of expenses or a commitment to improve a service.

During 2018-19 ASSIST helped to resolve **42** complaints in this way. Examples of cases which have been resolved this way can be found on the following pages.

If a Settlement is not appropriate, the Assessment process will help to decide if an investigation would be:

- Proportionate
- In the public interest
- Able to bring about a practical outcome

Complaints meeting these criteria are forwarded to the Investigation Team.

Settlements

Rent arrears waived for Housing Executive tenant

Following intervention by the Ombudsman the Northern Ireland Housing Executive agreed to waive the rent arrears of a man who left his accommodation without providing suitable notice.

The man had complained to the Ombudsman, stating that he had left his flat and moved into private accommodation because he was being intimidated by a new tenant who had just moved in below him. He stated that the new tenant had a history of anti-social behaviour and that he should not have been allowed to occupy the flat.

The Ombudsman wrote to the Housing Executive, asking it to provide confirmation that the complaint had been properly considered through the organisation's complaints procedure. It also asked for comments on each of the issues raised by the complainant.

The Housing Executive responded by setting out the allocation rules and policies for tenants. It stated that while it regretted the complainant's concerns, it was satisfied that all necessary steps had been taken to explain these rules and policies to him.

It also said that at all stages suitable support was made available to the tenant, and that his allegations were investigated at the earliest opportunity. It stated that the man had alternatives to terminating his tenancy and was made aware of these options, but chose not to use them.

However, the Housing Executive accepted that it had failed to open an Anti-Social Behaviour case, as would be normal practice in such situations. It offered to apologise to the complainant for this oversight, and as a goodwill gesture in order to resolve the man's complaint it agreed to waive the rent arrears which stood at almost £200.

The Ombudsman decided that this was an acceptable resolution, and that further enquiries or an investigation would not be proportionate. The complaint was therefore closed.

Trust apologises to patient following problems with procedure

A woman said she had been left in pain following a hospital iron infusion procedure. She also said she had been left with a large brown marking on the inside of her arm. She stated that hospital staff monitored her for 24 hours as they thought she was having an adverse reaction to the infusion. However, because she had read a patient information leaflet on the procedure the woman believed that the side effects were probably a result of a mistake in the way it had been carried out.

She complained to the hospital, asking them what had gone wrong. She also wanted to know how the procedures might be changed so that others would not experience the same problems.

Frustrated at the hospital's response, and their failure to accept responsibility, she brought her complaint to the Ombudsman.

The Ombudsman assessed the complaint and decided to look for an alternative resolution rather than carrying out a lengthy investigation.

The Trust were asked for their thoughts on what had happened. The Chief Executive replied, acknowledging that the staining which occurred was the result of iron leaking into the woman's body tissue. He also accepted that this could only have happened if a thin tube, known as a cannula, had somehow become removed from the vein.

He admitted that there had been an error in the way the procedure had been carried out. As a result he said that someone from the Trust would meet with the woman to explain this and to apologise to her.

The woman was told by the Ombudsman that the Trust had accepted responsibility for the error and that they would like to say they were sorry face to face. She said this had lifted a great weight off her. As she did not want to waste the hospital's resources she said she was happy with just a written apology.

Because of the Ombudsman's intervention and the satisfactory conclusion, it was decided that no further action was necessary.

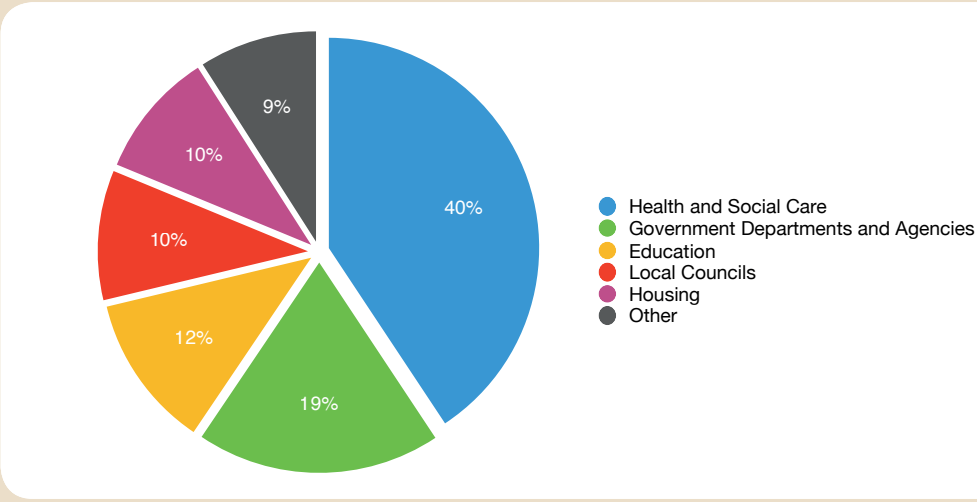
Section Two
Breakdown of complaints by sector

Analysis of complaints

The **762** complaints received during the year related to a wide variety of service providers. For the purposes of statistical analysis they are broken down into the six main areas below:

- Health and Social Care
- Government Departments and Agencies
- Local Councils
- Housing
- Education
- Other

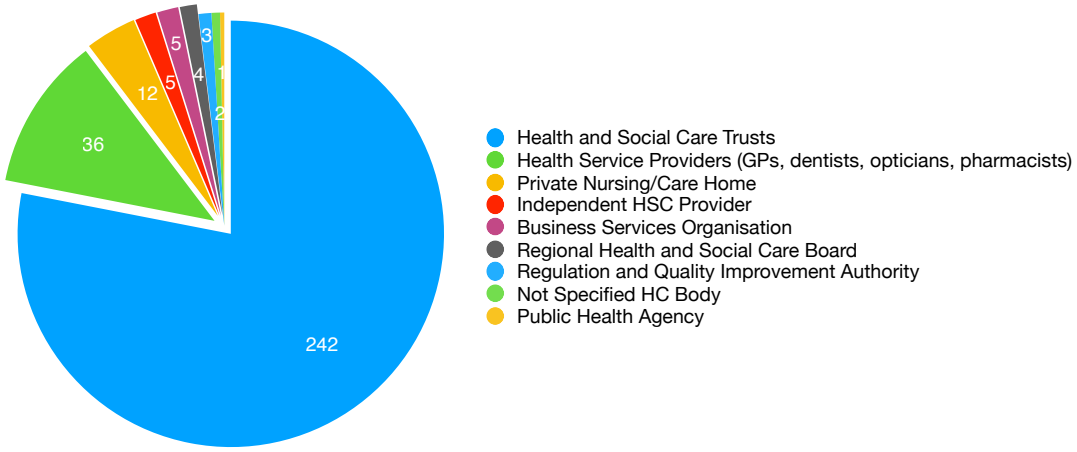
Percentage of complaints by sector 2018-19



Sector	Number of complaints
Health and Social Care	310
Government Departments and Agencies	143
Education	90
Local Councils	76
Housing	74
Other	69
Total	**762**

Health and Social Care

40% of all complaints to the Ombudsman related to Health and Social Care



The types of complaints received in this sector related to delays in care and treatment in hospitals and care homes, misdiagnosis of medical conditions, premature discharge from hospital, and poor communication with patients and their families. Some also involved specific complaints about decisions taken by GPs, doctors, consultants and social workers.

Breakdown of complaints about Health and Social Care

Sector	Number of complaints
Health and Social Care Trusts	242
Health Service Providers (GPs, dentists, opticians, pharmacists)	36
Private Nursing/Care Home	12
Independent HSC Provider	5
Business Services Organisation	5
Regional Health and Social Care Board	4
Regulation and Quality Improvement Authority	3
Not Specified HC Body	2
Public Health Agency	1
Total	**310**

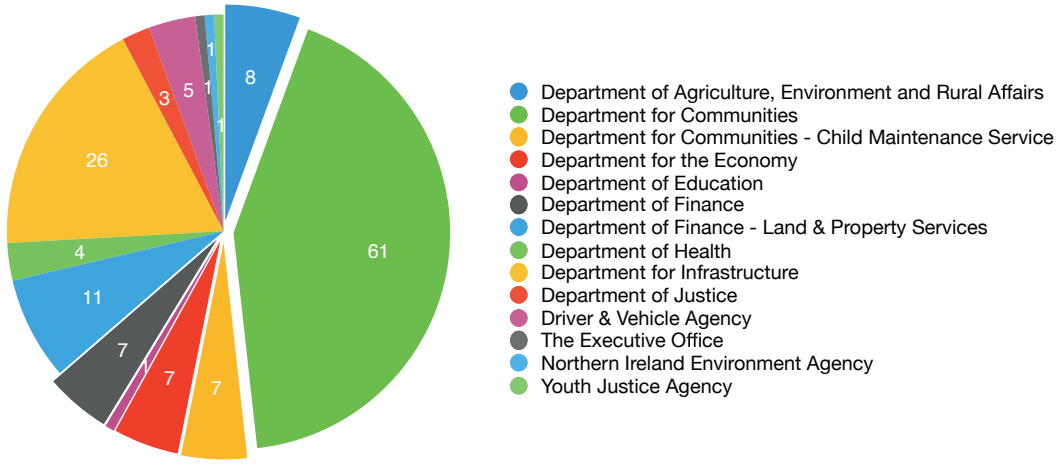
*A more detailed breakdown of these complaints, showing the stages at which they were determined by the Office, is available in Appendix 1.

Complaints about Health and Social Care Trusts

Trust	Number of complaints
Belfast Health & Social Care Trust	78
Northern Health & Social Care Trust	33
Northern Ireland Ambulance Service Trust	6
South Eastern Health & Social Care Trust	36
South Eastern Health & Social Care Trust (Prison Healthcare)	7
Southern Health & Social Care Trust	32
Western Health & Social Care Trust	50
Total	**242**

Government Departments and Agencies

19% of all complaints to the Ombudsman related to Government Departments and Agencies



Government Departments

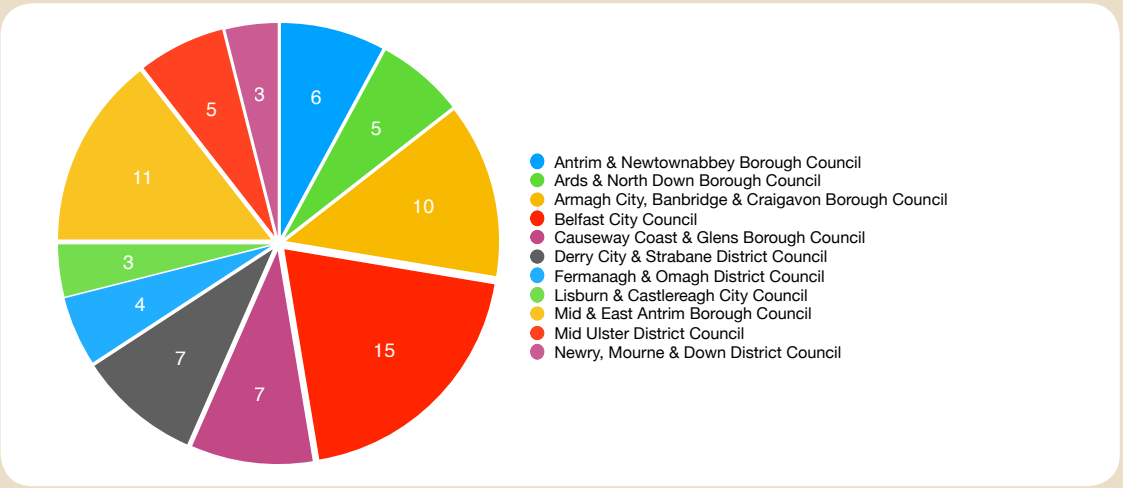
Examples of complaints about government departments include issues relating to child support payments, departmental responses to planning applications, the administration of Single Farm Payments, the administration of Personal Independence Payments, and selection procedures for the civil service Voluntary Exit Scheme.

Department or Agency	Number of complaints
Department of Agriculture, Environment and Rural Affairs	8
Department for Communities	61
Department for Communities - Child Maintenance Service	7
Department for the Economy	7
Department of Education	1
Department of Finance	7
Department of Finance - Land & Property Services	11
Department of Health	4
Department for Infrastructure	26
Department of Justice	3
Driver & Vehicle Agency	5
The Executive Office	1
Northern Ireland Environment Agency	1
Youth Justice Agency	1
Total	**143**

*A more detailed breakdown of these complaints, showing the stages at which they were determined by the Office, is available in Appendix 1.

Local Councils

10% of all complaints to the Ombudsman related to Local Councils



Local Councils

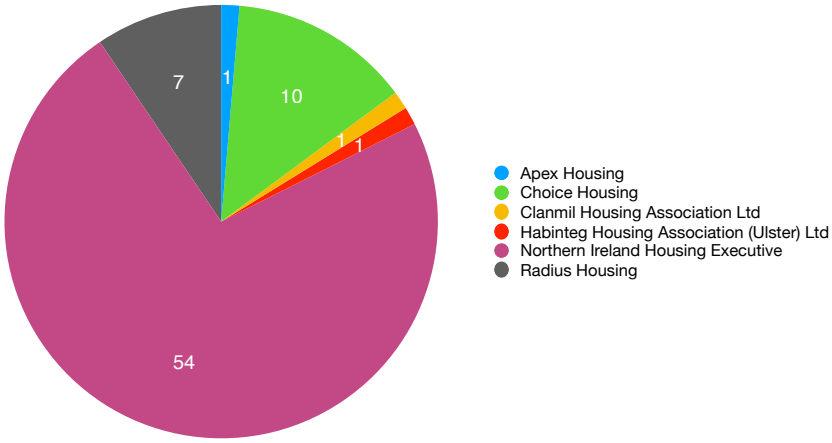
Examples of complaints about local councils include concerns about planning decisions taken by councils, enforcement of planning breaches, and issues relating to tendering for local government projects.

Department or Agency	Number of complaints
Antrim & Newtownabbey Borough Council	6
Ards & North Down Borough Council	5
Armagh City, Banbridge & Craigavon Borough Council	10
Belfast City Council	15
Causeway Coast & Glens Borough Council	7
Derry City & Strabane District Council	7
Fermanagh & Omagh District Council	4
Lisburn & Castlereagh City Council	3
Mid & East Antrim Borough Council	11
Mid Ulster District Council	5
Newry, Mourne & Down District Council	3
Total	**76**

*A more detailed breakdown of these complaints, showing the stages at which they were determined by the Office, is available in Appendix 1.

Housing

10% of all complaints to the Ombudsman related to housing



Housing

Examples of complaints about this sector include how housing associations responded to allegations of anti-social behaviour, issues relating to property repairs and management, as well as about the administration of housing waiting lists and requests for transfers..

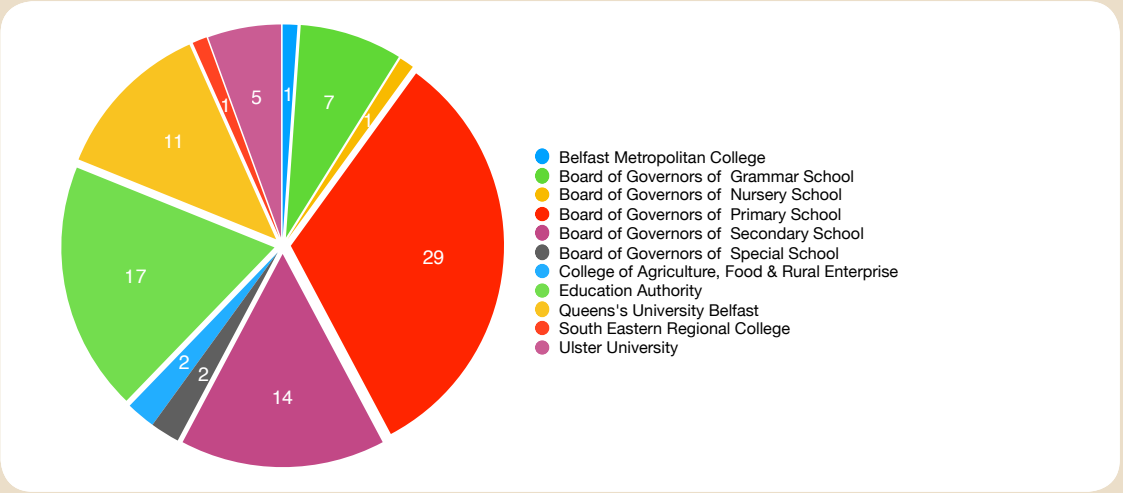
Complaints about housing

Housing Authority	Number of complaints
Apex Housing	1
Choice Housing	10
Clanmil Housing Association Ltd	1
Habinteg Housing Association (Ulster) Ltd	1
Northern Ireland Housing Executive	54
Radius Housing	7
Total	**74**

*A more detailed breakdown of these complaints, showing the stages at which they were determined by the Office, is available in Appendix 1.

Education

12% of all complaints to the Ombudsman related to Education



Education

Complaints in the area of education related to the handling of allegations of bullying, the provision of child protection and support services, and the ways schools dealt with pupils with Special Educational Needs.

Complaints about education

Housing Authority	Number of complaints
Belfast Metropolitan College	1
Board of Governors of Grammar School	7
Board of Governors of Nursery School	1
Board of Governors of Primary School	29
Board of Governors of Secondary School	14
Board of Governors of Special School	2
College of Agriculture, Food & Rural Enterprise	2
Education Authority	17
Queen's University Belfast	11
South Eastern Regional College	1
Ulster University	5
Total	**90**

*A more detailed breakdown of these complaints, showing the stages at which they were determined by the Office, is available in Appendix 1.

Section 3
Investigation Team

Where the ASSIST Team decide that they cannot resolve a complaint and there is evidence that the matter requires further detailed investigation, the case is forwarded to the Investigation Team. A total of **98** cases were referred in 2018-19. This is an increase of **21%** on the previous year.

Privacy and confidentiality

An Ombudsman is often seen as providing an alternative to court. Investigations are inquisitorial in nature, rather than adversarial, so much of an investigation is conducted through correspondence. However, this does not diminish the effectiveness of an investigation as an Ombudsman has powers to interview officials where appropriate and compel bodies to provide them with documents.

An Ombudsman investigation is therefore able to obtain information which has not been previously seen by a complainant. This can even include legal advice.

To protect both the complainant and those giving evidence to the investigation, all investigations are carried out in private.

Through this process the investigator is able to build up a detailed understanding of events in order to help the Ombudsman make a fair and balanced judgment on the complaint.

Public Reports

Despite the confidential nature of the investigation process, a final report can be published if the Ombudsman believes it to be in the public interest.

The Ombudsman recognises that there are a number of factors in deciding whether publication of a report is in the public interest. For instance where the matter relates to public health, patient safety or accountability for public funds.

More generally the Ombudsman believes that publishing her investigation reports helps to make public bodies more open and accountable, and that awareness of their decision-making can improve the overall level of trust and confidence in the public sector.

Publication of reports also allows the Ombudsman to show how her investigations are carried out and how her decisions are arrived at. This openness and transparency principle leads to greater understanding of the Ombudsman's processes.

The names of complainants are not included in the published report, nor the names of anyone working in a public body (unless there are good reasons for doing so). The body complained of is usually named.

In 2018-19 the Ombudsman published **27** investigation reports.

Recommendations and outcomes

During the year the Investigation Team completed **73** investigations, a **9%** increase on the number completed in 2017-18.

The Ombudsman reported on 117 separate issues of complaint. **70%** were upheld or partially upheld. A total of **30%** were not upheld.

The role of an Ombudsman is to promote good governance and improve accountability in public administration as well as providing remedy in individual cases. One of the ways the Office seeks to have a positive impact on public services is by making recommendations where maladministration has caused injustice.

The Ombudsman can ask a public service provider to:

- Apologise to the complainant
- Review their policies and guidance
- Disseminate the learning from the complaint
- Provide a financial remedy in acknowledgement of monetary loss or injustice

The most common recommendations made in 2018-19 were for service improvement or an apology to the complainant.

Compliments about our work

During the year the Office received a number of letters and emails from members of the public who had used our service

We would like to express our sincerest thanks to you and your staff, in particular the investigating officer, for his prompt return of our various queries.

Thank you again for your personal attention. Your thoroughness in the investigation was beyond my expectations with regard to explanations. The care taken by your staff and the independent advisors was exceptional.

I would also like to thank the case worker who has been very professional.

Thank you so much for all your hard work and commitment to my case. I cannot tell you how much I appreciate this.

Thank you for all of your help in resolving my complaint ... I am very grateful for your efforts. And thank you for listening to what I had to say throughout the process.

I am very happy with publication of the report as it has been fully comprehensive and it has answered all my issues.

I would like to thank you for taking the time to investigate my complaint in relation to my daughter's care

Once again can I offer my sincere thanks and gratitude to the Ombudsman for investigating my case.

I would like to sincerely thank you for the professional and sensitive manner in which my complaint has been handled and investigated.

Section Four
Summaries of Investigations Published During the Year

Sector: Health and Social Care

Trust apologises to complainant following Ombudsman investigation

Body complained of: Belfast Health and Social Care Trust

The complaint

The Belfast Health and Social Care Trust apologised to a complainant for the care and treatment her mother received while a patient in the Mater Hospital.

The patient had been admitted to the hospital following a stroke. She had a fall in a bathroom on the ward and sustained a fractured hip. She was transferred to the Royal Victoria Hospital for surgery, but sadly died the following day. Her daughter complained that she should not have been left unattended in the bathroom. She also complained about the Trust's investigation into the incident.

The investigation

The Ombudsman obtained all relevant documents, including the Trust's response to the initial complaint. Interviews with Trust staff were also carried out, and an independent professional advisor consulted.

The outcome

After considering the evidence, the Ombudsman found that it was appropriate for the patient to have been left unattended in the bathroom.

However, she also concluded that the patient was put at risk by nursing staff because they did not ensure she was wearing suitable footwear at the time.

She was unable to say whether this was a contributing factor in the fall as the patient was unable to communicate and there were no witnesses.

In relation to the Trust's own investigations into the incident, the Ombudsman found a number of significant failings. The investigation took far too long, had no independent Chair, and failed to look at the issue of the patient's footwear.

The Ombudsman also found that the Trust's own investigation report made incorrect conclusions about the role of ward staff in reporting the incident. In particular it wrongly stated that ward staff did not escalate the incident, and wrongly concluded that senior management were not aware of it.

In addition to the learning identified by the Trust as a result of this complaint, the Ombudsman also recommended that the Trust take the necessary action to ensure that all relevant ward staff have been involved in falls prevention training or instruction, and in particular to highlight the importance of patients wearing appropriate footwear.

The Trust were also asked to provide a sincere and meaningful written apology to the patient's daughter for the injustice identified in the report, and to pay her £750 to acknowledge her distress.

Sector: Health and Social Care

Investigation into the care and treatment of patient in Armagh nursing home

Body complained of: Ard Mhacha Nursing Home, Armagh

The complaint

The Ombudsman received a complaint from a man who claimed that his father had suffered poor care and treatment while a resident of Ard Mhacha Nursing Home, Armagh.

The investigation

The investigation looked at the assessments carried out for the resident when he was admitted to the Home. It also looked at his pain management programme, his treatment for constipation, and allegations that he had suffered severe weight loss during his time there.

The Ombudsman examined all relevant notes and records from the Home, as well as advice from a specialist independent advisor. She also looked at documents from the Southern Health and Social Care Trust, which had carried out its own investigation into the complaint.

The outcome

She concluded that the Home's assessments and care plans were largely adequate. However, she also found that it had underestimated the resident's risk of a fall, and that it was inconsistent in its assessment of his mental state.

The Ombudsman found that following a fall, the resident's pain management was also not properly managed. Although he was found not to have suffered a fracture, he had spent 4 days without pain relief before going to hospital for an x-ray.

In relation to the concerns about the resident's weight loss, the findings of the Trust's investigation and the professional advisor's comments were both considered. These stated that the total weight loss was less than that which warranted a referral to a dietician. This part of the complaint was not upheld.

The Ombudsman recommended that the Home apologise to the complainant for the failures in care identified in the report. She also made recommendations about the Home's pain management and falls management procedures. These recommendations were accepted.

Sector: Health and Social Care

Hospital conditions not the cause of patient's pneumonia

Body complained of: Belfast Health and Social Care Trust

An investigation into a man's complaint found that the conditions on a hospital ward did not cause his wife to contract pneumonia.

The patient was admitted to the Emergency Department of Belfast's Royal Victoria Hospital after suffering a fractured ankle. She had a number of other underlying health conditions. She had surgery on her ankle, but later developed pneumonia and a short time later suffered two cardiac arrests in hospital. She sadly passed away the following day.

The complaint

The man made a number of allegations about his wife's care in the hospital. He complained that she contracted hospital-acquired pneumonia because the ward she was being treated in had a broken window and a malfunctioning heating system.

He also alleged that hospital staff did not manage the fluids his wife was being given, and that her diabetes was not sufficiently taken into account by the medical staff who were treating her.

The investigation

An independent consultant physician was asked for his opinion on whether the conditions on the ward caused the patient to contract pneumonia. He stated that hospital-acquired pneumonia is caused by hospital germs and can be contracted by patients who lack immunity, and not merely by those who are exposed to a cold environment.

The outcome

The Ombudsman accepted the advice that the poor facilities would not have caused the patient to contract the condition and did not uphold this element of the complaint. However, she did note the lack of additional measures put in place to ensure the patient's comfort, and welcomed the Health Trust's apology on this issue.

The investigation found that although Trust staff did not properly monitor and adequately record the patient's fluid input, there was no evidence that this failing caused the patient's condition to deteriorate.

The Ombudsman's independent advisor also stated there was evidence that the patient's blood glucose levels were measured, which would indicate that her diabetes was taken into account and was under control during her time in hospital.

This part of the complaint was not upheld.

Sector: Health and Social Care

Patient was discharged prematurely from hospital's Emergency Department

Body complained of: Southern Health and Social Care Trust

The complaint

A patient who had attended Craigavon Area Hospital complained that she was unfit to be discharged from the hospital's Emergency Department, which she had been admitted to a number of hours earlier.

She was admitted complaining of a migraine headache, vomiting and diarrhoea. She stated that after being examined and given medication, she was ordered out of bed by a doctor and taken into the waiting area of the Emergency Department.

When she later took a taxi home, she stated she continued to vomit during the journey and was unsteady on her feet. She complained that staff were unaware she had received morphine earlier that day and might still be under the influence of it. She believed that the Trust had failed in its duty of care to her.

The investigation

All relevant material in relation to the patient's complaint was obtained, and independent professional advice received from a consultant in emergency medicine.

The Ombudsman's investigation found that staff in the Emergency Department were aware that the patient had been given morphine earlier in the day. This element of the complaint was not upheld.

The outcome

However, failures were found in relation to the following matters:

- After receiving treatment, the patient should have been moved to an observation ward and not the waiting room
- Observations should have been carried out by Trust staff and her discharge delayed until the Emergency Department doctor was able to determine whether she was well enough to tolerate oral intake of fluids and food.
- Although the doctor recalls telling the patient to re-attend if her symptoms were to return or worsen, this advice should have been recorded but was not.

The Ombudsman recommended that the Trust apologise to the patient for the injustice suffered.

Sector: Health and Social Care

Investigation into complaint that medical staff's slow response led to patient losing his sight

Body complained of: Northern Health & Social Care Trust & Belfast Health & Social Care Trust

An investigation found failings in the way that medical and ophthalmology staff responded to a man's eye condition while he was a patient at the Antrim Area Hospital.

The complaint

The man's daughter complained to the Ombudsman that her father would not have gone blind had the seriousness of his condition being spotted earlier.

The investigation

All relevant documentation in relation to the patient's treatment was obtained. Independent professional advice was sought from a number of advisors to help in the assessment of the clinical judgment of the health professionals involved in the patient's care and treatment.

This advice stated that when the patient's condition was first spotted it was not given an appropriate assessment by medical staff. Given the seriousness of some red-eye conditions the advisor stated that it potentially needed to be referred to the eye casualty department.

The advice also stated that when the patient was seen by ophthalmology staff three days later, they made the correct decision not to give him intra-vitreal antibiotics (a technique requiring an injection to the eye). However, this decision should have been reviewed the next day. Instead the review was arranged as a routine appointment for nine days later.

The outcome

After considering all of the evidence, the Ombudsman concluded that the ongoing significance of the patient's developing 'red eye' condition should have been further and sooner investigated and escalated. She found:

- That there was a failure by the Northern Health and Social Care Trust to appropriately assess and seek timely expert advice regarding the patient's eye condition. This failure continued after the initial inadequate assessment as several other doctors and consultants examined or reviewed him.

- That the system in place at the Belfast Health and Social Care Trust for handover, referral, prioritisation, and monitoring of patients did not ensure that he was reviewed as a priority.

- That an earlier diagnosis would have ensured that antibiotics were given at the appropriate time and this would have much improved the chances of the patient retaining his vision.

In view of her findings it was recommended that the complainant should receive a written apology for the failures identified in the report, and be provided with a financial remedy of £1000.

The Ombudsman also made a number of recommendations to the two Health and Social Care Trusts involved in the case, in particular that they jointly conduct a review of the Ophthalmology service provided to patients in the Northern Health and Social Care Trust, focusing on eye casualty and inpatient referral.

Sector: Health and Social Care

Investigation finds that patient was given adequate information about her medical condition on discharge from hospital

Body complained of: South Eastern Health & Social Care Trust

The Ombudsman found that staff from the Ulster Hospital followed full and appropriate procedures when they discharged a patient who had been in their High Dependency Unit while undergoing treatment for a serious illness.

The complaint

The patient's partner came to the Ombudsman after he and the South Eastern Health and Social Care Trust were unable to resolve his complaint.

He stated that his partner had been diagnosed with Bacterial Meningitis and septicaemia. She had spent a short period in the High Dependency Unit of the Ulster Hospital before her eventual discharge from the hospital.

He alleged that when she was discharged she was not given enough information on Bacterial Meningitis and its after-effects, possible brain injury, and the after-effects of being a patient in a High Dependency Unit.

The investigation

The Ombudsman considered evidence from the Trust and independent professional advisors, and examined the patient's medical records during her time in hospital.

The outcome

After carefully considering the evidence she concluded that the patient's overall discharge planning was appropriate and in line with national guidance. She also noted that since the patient's stay at the hospital, the Trust now provide patients with information leaflets on discharge when they have been admitted with Bacterial Meningitis.

The complaint was not upheld.

Sector: Health and Social Care

Complaint about GP not upheld

Body complained of: The Surgery GP Practice, Comber

An Ombudsman investigation found that a GP provided appropriate care and treatment to a patient who was concerned about a lump in her breast.

The complaint

The patient stated that the lump could only be detected while standing up, and complained that the doctor only examined her when she was lying down. A referral to the breast clinic was made after the third consultation, where cancer was subsequently diagnosed. The patient stated that she should have been referred earlier.

The investigation

The investigation heard from the GP's practice, which stated that the Trust's Consultant Surgeon indicated that the abnormalities that were detected via mammogram would not have been palpable clinically. The practice added that in its opinion, the patient was referred to the breast clinic at the appropriate stage and was examined according to the practice's protocol.

An independent professional advisor stated that the evidence pointed to the lump not being clinically detectable by palpation (the process of feeling an object in or on the body to determine its size, shape, firmness, or location) and that the examination method used by the doctor, with the patient in a semi-reclining position, was consistent with good practice and relevant standards. They also stated that there was no evidence to suggest that the doctor should have made the referral sooner.

The outcome

Following careful consideration of responses from the patient, the practice and the independent professional advisor, the Ombudsman decided that there was no evidence of a failure in the care and treatment by the GP.

The complaint was not upheld.

Sector: Health and Social Care

Trust failed to provide adequate care and treatment to patient during last weeks of her life

Body complained of: Southern Health and Social Care Trust

The complaint

The daughter of a patient who passed away in Craigavon Area Hospital complained about the nutritional and nursing care provided to her mother during the last weeks of her life. She also complained that a member of the nursing staff attempted to feed her mother via an artificial method without sedation, contrary to her mother's wishes and against the advice of the consultant.

The investigation

In order to investigate the complaint the Ombudsman's Investigating Officer obtained from the Trust all relevant documentation. Clinical advice was also obtained from three Independent Professional Assessors (IPAs).

The Investigating Officer established that at the beginning of her eight week period in hospital the patient was put on a diet of soft food and normal liquids. However, she was soon moved onto thickened liquids by her medical team, her intake of which declined over the following weeks.

Within one month her weight reduced by over 8kg, leading to her consultant recommending artificial feeding via a nasogastric tube (a special tube that carries food and medicine to the stomach through the nose). Over the course of the next week there were a number of attempts to use this method but all failed.

At this stage the medical team consulted with the complainant, who agreed that there would be no further attempts to use this method on her mother unless she was sedated.

The patient was then fed via total parenteral nutrition (a method of supplying nutrition through a vein) for a two week period, but died a short time after.

In assessing the quality of the care provided to the patient the Ombudsman noted that she was severely ill with pneumonia throughout her time in hospital and was being monitored for possible dementia. This led one of the IPA's to state that irrespective of her nutritional status the patient was at risk of death.

However, the Ombudsman established that on five occasions the dietitian team highlighted that she was not meeting her nutritional requirements and that artificial feeding should be considered. However, the medical team did not attempt artificial feeding until 16 days after the initial recommendation.

The outcome

Based on clinical advice the Ombudsman concluded that given the significant co-morbidities and frail health, earlier intervention may not have prevented the sad outcome of the patient's death. However the Ombudsman considered that appropriate and timely intervention may have alleviated her discomfort and distress in the last weeks of her life.

The Ombudsman noted that the patient had received excellent care from the dietitians. However, she criticised

the delay by the medical team in implementing the recommendations of the dietitian team. She highlighted the fact that both sets of notes and records were maintained separately and as a result were not readily available for other members of the multidisciplinary team to review.

It was acknowledged that the patient was in poor health when she died. However, the Ombudsman also considered the principles enshrined in the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) and the European Social Charter (ESC). The ESC enshrines the right to the protection of health and contains specific provisions relating to older people. This guarantees physical and psychological integrity and prohibits non-consensual medical treatment. The Ombudsman concluded that in attempting to insert a NG tube without sedation against the patient's stated wishes and in failing to address her nutritional needs in a more timely manner, the Trust did not have sufficient regard for her rights.

The Ombudsman also found failures in care and treatment with regard to the triaging of the Speech and Language Team referral, and a number of instances of inadequate record keeping.

By way of remedy the Ombudsman recommend that the Trust apologised to the complainant and her family for the failings, and provide a payment in acknowledgment of the injustice to the patient's family.

She recommend that the Trust provide an action plan specifying how the failings identified in the report will be shared with the medical and nursing teams involved in the patient's care, with the focus of the discussion with these teams on learning and improvement.

Sector: Housing

Housing Executive made 'fair and reasonable efforts' to address concerns of man who complained about his neighbour's anti-social behaviour

Body complained of: Northern Ireland Housing Executive

The complaint

The Ombudsman rejected a complaint from a member of the public who alleged that the Northern Ireland Housing Executive (NIHE) had failed to deal with the anti-social behaviour of his neighbour, who was a Housing Executive tenant.

At meetings with the NIHE the man made numerous complaints concerning noise nuisance coming from the inside and outside of the neighbouring property. By way of resolution he stated that he wanted either the tenant evicted or the NIHE to buy or rent his property, thereby allowing him to relocate.

After being told that this was not possible, the man complained to the Ombudsman.

The investigation

In considering a complaint of maladministration, the Ombudsman's role is to examine whether the NIHE decision-making process was fair and met its obligations.

The investigation obtained all relevant documentation relating to the complaint. This included the NIHE's 'Anti-social Behaviour Manual', its files relating to the man and his neighbour, and relevant information from the local Council. Interviews with NIHE staff were also carried out.

The investigation revealed that in this case the NIHE properly followed its anti-social behaviour policy.

It liaised extensively with the relevant bodies such as the PSNI and obtained legal advice. It also interviewed both the man and his neighbour on more than one occasion, arranged mediation between the two parties and met with the man's political representatives.

Further, it offered to arrange the installation of monitoring equipment and to pay for further mediation between the parties.

The outcome

After considering all of the evidence the Ombudsman was satisfied that the NIHE had made fair and reasonable efforts to address the man's concerns and that there was a lack of independent, robust and verifiable evidence which would justify NIHE taking eviction or other action against the man's neighbour.

The complaint was not upheld.

Sector: Housing

Ombudsman asks Housing Executive to look again at grant application

Body complained of: Northern Ireland Housing Executive

A complaint from a member of the public about the way the Housing Executive handled her request for a grant to buy a property was upheld by the Ombudsman.

The complaint

The woman believed that the Housing Executive was responsible for her having to sell her home due to anti-social behaviour from other tenants.

The investigation

The Ombudsman's investigation looked at whether the Housing Executive followed its policies and procedures on grant allocations of this type. It also looked at how it dealt with the subsequent complaint by the woman.

The outcome

The Ombudsman found that when dealing with the request, the Housing Executive did not follow the processes laid out in its Grants Manual. It also did not maintain appropriate records to indicate that the application was assessed against a number of 'exceptional circumstances' which may have allowed the grant to be awarded. Finally, it failed to give the woman a full explanation of its decision.

Because of these failures the Ombudsman asked the Housing Executive to look again at the grant application. However, she stated that the payment of any grant was still a discretionary decision for the Housing Executive to make.

To help reduce similar complaints in the future, the Ombudsman also recommended that the Housing Executive make changes to its Grant Manual, and stressed the importance of good record keeping and providing clear, unambiguous and accurate responses to applicants.

Sector: Central Government

Ombudsman critical of Transport NI's failure to provide and record reasons why four planning applications were considered acceptable

Body complained of: Transport NI

An investigation into the way Transport NI (now DfI Roads) dealt with consultation responses to a planning application led to the Ombudsman making a number of recommendations.

The complaint

The investigation began after a complaint regarding how the Agency assessed and processed consultation requests regarding planning applications for four proposed agricultural developments near the complainant's home.

The investigation

The investigation found that the Agency:

- Failed to record the reasons why it thought the four planning applications were acceptable
- Failed to record the reasons why it thought a detailed Transport Assessment of the applications was not necessary, and why the transport impact was deemed insignificant
- Failed to record the reasons why it thought the accident history in the area was not relevant

The outcome

Although the investigation found no evidence to refute Transport NI's assertion that their decisions were appropriate, the absence of a record of those decisions led the Ombudsman to conclude that there had been maladministration.

The Ombudsman recommended changes to the process for considering and responding to consultations on planning applications. She also recommended that the complainant receive an apology for the failings, and a payment of £350.

Sector: Central Government

Department asked to refund money to complainant

Body complained of: Department for Agriculture, Environment and Rural Affairs

The Department for Agriculture, Environment and Rural Affairs was asked to refund money it recovered from an applicant of the Single Farm Payments scheme (SFP) after an investigation found that unclear Departmental guidance caused confusion among claimants.

The complaint

The investigation began after the complainants (a husband and wife) contacted the Ombudsman to say that they had claimed money under the scheme in all good faith, in the belief that a quarry they owned was eligible for the subsidy. Following an inspection of the land the Department declared it was not eligible, and subsequently recovered the payments as well as applying an overpayment penalty. The complainants then applied to have this decision reviewed. The Department's review determined that the payment recovery and the penalties applied were appropriate.

The investigation

The Ombudsman's investigation found that the Department's guidance to applicants was confusing. In particular, in successive Departmental booklets published between 2005- 2010 (the period in which the complainant's claims were made), the section on ineligible land contained a long list of examples. However, the list did not include quarries.

The investigation found that 'quarry' was only added to the list in 2011.

In considering the issue, the Ombudsman had regard to the third principle of Good Administration 'Being open and accountable' which requires that public bodies ensure that information, and any advice provided, is clear, accurate and complete.

The outcome

The Ombudsman decided that prior to 2010, the guidance was incomplete, misleading and requiring of considerable clarification, and that therefore it failed to meet the standard required by the principle.

As a result she recommended that the Department:

- Provide the complainants with a payment to include an amount equivalent to the deductions and penalties applied in relation to the area of the quarry, as well as £250 to reflect the time, trouble and stress they suffered pursuing their complaint.
- Provide the complainants with an apology for the failings identified within the report.
- Share the learning from the report with the Department's inspectorate staff.

Sector: Local Government

Council dealt appropriately with planning application

Body complained of: Mid & East Antrim Borough Council

An investigation by the Public Services Ombudsman found that Mid & East Antrim Borough Council dealt properly with a planning application for a house extension, despite objections from the applicant's neighbours.

The complaint

The neighbours complained to the Ombudsman that the Council did not properly consider the impact of the proposed extension to their privacy. They also complained that they had not been informed of changes to the plans, and that the Council had failed to take appropriate action about what they thought was a breach of planning permission.

The investigation

The Investigating Officer obtained from the Council all relevant documents, met with the complainants and visited and viewed the property.

The Ombudsman's role in investigating complaints about planning matters relates to the administrative actions of the Council. She cannot challenge a discretionary decision based on professional judgment unless there have been errors in the decision making process.

The outcome

After considering the evidence the Ombudsman found that the Council processed the planning application properly, and dealt fairly with the alleged breach of planning permission.

However, she did find failures in certain aspects of the Council's record keeping and complaint handling, for which she recommended that the complainants receive an apology

Sector: Local Government

Complaint about planning application partially upheld

Body complained of: Newry, Mourne and Down District Council

A man's complaint about how his planning application was dealt with was partially upheld by the Ombudsman.

The complaint

The man alleged that both the former Department of the Environment, and Newry, Mourne and Down District Council, did not process his application properly.

He alleged that the planning officer dealing with the application refused to take account of the information given to her by his planning consultant. As a result he believed her recommendation to refuse the application was flawed. He also tried to get reimbursement for the cost of engaging the planning consultant.

Although the plans were eventually approved by the Council's Planning Committee, the man claimed that he had still suffered an injustice.

The investigation

The investigation examined all relevant documents, and obtained independent professional advice in relation to aspects of the case.

In considering complaints of this nature it was noted that planning officers are required to undertake balanced judgments which often do not meet with the expectations of applicants.

It was the planning officer's decision in this case that the application was not acceptable in planning terms and should be recommended for refusal.

The outcome

The Ombudsman concluded that the planning officer considered the appropriate policies and took the planning consultant's views into account before making her decision. She did not uphold this element of the complaint.

She also noted that as the continued involvement of a planning consultant was the man's own decision, it would not be appropriate to recommend that his fees be reimbursed.

She did, however, find that the man should have been told earlier about one of the reasons why his application was to be refused. She also found that the council did not provide him with an adequate response after he made a complaint.

Further, she found that the Planning Committee did not record the reasons why they decided to grant permission for the application. Although this did not lead to an injustice to the man, the Ombudsman commented that this was a failure to meet the principles of good administration, and a breach of the Committee's own protocol.

In light of the frustration, uncertainty and the time and trouble in bringing the complaint, the Ombudsman recommended that the Council issue the complainant with an apology and a financial remedy for the failings which were identified in the report.

Section Five
Performance Analysis

How we measure performance

NIPSO's operational efficiency and effectiveness is measured through key performance indicators (KPIs). These focus on the time taken to assess complaints and complete investigations. Complementary qualitative assessments are completed through established internal procedures and the Ombudsman remains fully committed to quality as well as timeliness. The Office's maladministration KPIs, together with the recorded performance in 2018-19, are as follows:

Indicator	2018-19 Target	2018-19 Achieved
KPI 1 – measures how quickly we make a decision on whether the Ombudsman can accept a complaint for further assessment. We aim to inform the complainant within 2 weeks or less of their complaint being received in 90% of cases	90%	93%
KPI 2 – measures how quickly we decide on what action we can take on a complaint which has been accepted for assessment. We aim to complete this assessment and inform the complainant of the decision within 10 weeks of their complaint being received.	70%	70%
KPI 3 – measures how quickly we reach a decision on the investigation of a complaint and share the draft report with the body and the complainant. We aim to complete this within 50 weeks of the decision at KPI 2 being made.	70%	68%

Performance Commentary

Where targets were narrowly achieved or missed this must be viewed in the context of the adequacy and short-term nature of funding available to NIPSO, and the significant ongoing budgetary uncertainties. The predominant risk factors that are of relevance to NIPSO's complaints case handling performance are:

(i) Increasing case numbers beyond forecast, further risking the achievement of KPIs 1-3 (e.g. a 60% increase in maladministration complaints numbers since 2015-16);

(ii) Staff turnover and inefficiencies, partly associated with the enforced reliance on short term staff and short term contracts; and

(iii) In the absence of the Assembly, uncertainty over future years' resources and inability to identify and mitigate future financial pressures, leading to an inability to achieve business objectives and to reputational damage.

Despite these risks KPI 1 (the ***can*** we investigate decision) was met in 93% of cases – 3% above the 90% target. The average number of working days taken at this stage was 10 working days.

The reported percentage performance for a decision at KPI 2 (assessment of whether a case ***should*** be investigated) was 70%. The achievement of this target given the increased caseload in the ASSIST team is noteworthy. However, the average number of days taken at this stage was 90. This exceeds the 10 week target completion time and can be largely attributed to the growth in volume of decisions being made at KPI 2 stage – a 38% increase to 365 in 2018-19 from 265 in 2017-18.

The KPI 3 performance target relates to the time taken to issue a draft investigation report and was met in 68% of cases. This performance is just short of the target of 70%. Considerable staffing pressures are being experienced in the investigations team, as a result of staff shortages and the level of staff turnover. In that context the KPI 3 achievement rate is commendable, noting also that the number of investigation cases in progress as at the year-end has grown significantly to 133 – up 23% from the 108 at the start of the year.

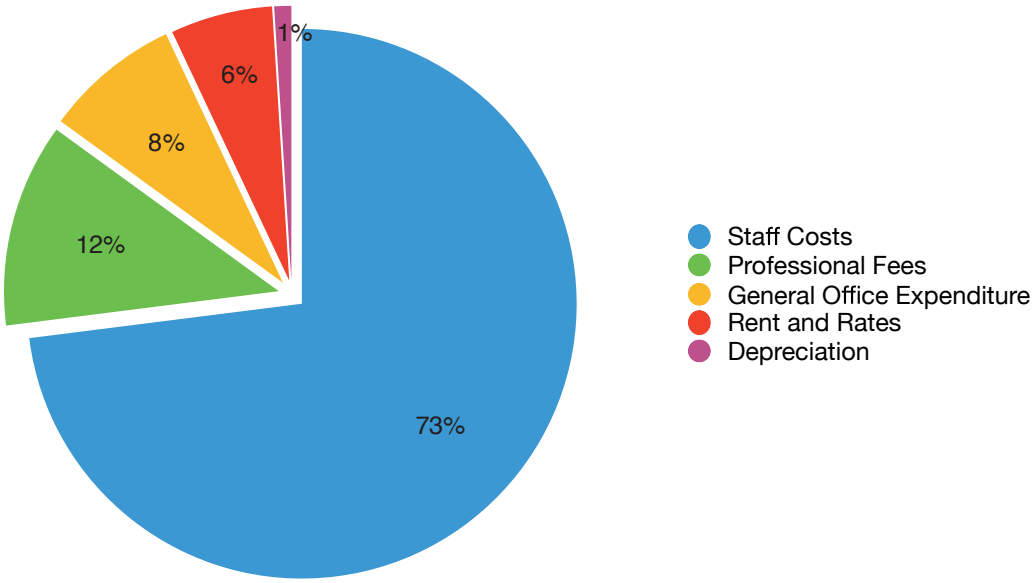
Financial performance

The following summarises NIPSO's audited expenditure during 2018-19

(All £k)	Maladministration (incl NIJAO)	Local Gov't Ethical Standards (LGES)	Total
Staff Costs	1,559	282	1,841
Other Administration Costs	545	155	700
Total expenditure	**2,104**	**437**	**2,541**

In overall terms this represents a growth in expenditure of some 12% from the £2,260k incurred in 2017-18. The increase is reflective of growing demands in relation to NIPSO's rapidly expanding maladministration complaints case load, additional Local Government Ethical Standards work load and expansions in jurisdiction, including Own Initiative.

Illustrated opposite is the breakdown of NIPSO's resource expenditure for 2018-19.



Staffing

The breakdown of actual staff in post (headcount) at 31 March 2019 was as follows:

	Male	Female	Total
Ombudsman/Deputy Ombudsman	1	1	2
Other Senior Management Team	2	2	4
Other Staff	13	27	40
Total	**16**	**30**	**46**

The total of 46 represents an increase of 15% from the 40 in post a year earlier.

Absence Data

Sickness absence data for 2018-19 was as follows:

Working Days lost 2018-19	Average days lost per WTE member of staff	Absence Rate 2018-19 %
177	4.7	2.2%

Accountability for NIPSO Performance

The Ombudsman and her Senior Management Team (SMT) monitor performance across all functions at monthly and quarterly SMT meetings. In addition the Audit and Risk Committee review risk as well as financial and casework performance and are provided with assurance in these areas by reports from an Internal Audit Service and the Northern Ireland Audit Office.

Appendix One
Further Casework Statistics

Health and Social Care

	Brought Forward @ 01/04/18	Complaints Received in 2018-19	Determined at Initial Assessment	Determined at Assessment	Determined at Investigation	Carried Forward @ 31/03/2019
H&S Care Trusts	104	242	105	84	41	116
Health Service Providers	8	36	18	5	5	16
Independent HSC Provider	3	5	2	0	1	5
Not Specified HC Body	0	2	2	0	0	0
Public Health Agency	0	1	0	1	0	0
R H&S Care Board	3	4	3	2	2	0
RQIA	2	3	1	2	0	2
Private Nursing/ Care Home	6	12	7	4	2	5
Business Services Organisation	0	5	4	0	0	1
Total	**126**	**310**	**142**	**98**	**51**	**145**

Government Departments and Agencies

	Brought Forward @ 01/04/18	Complaints Received in 2018-19	Determined at Initial Assessment	Determined at Assessment	Determined at Investigation	Carried Forward @ 31/03/2019
Driver & Vehicle Agency	1	5	2	2	1	1
Northern Ireland Environment Agency	2	1	0	0	1	2
Youth Justice Agency	0	1	0	0	0	1
Department for Communities	4	61	41	14	1	9
Department for Communities - Child Maintenance Service	1	7	4	3	1	0
Department for Infrastructure	4	26	18	8	1	3
Department for the Economy	1	7	0	4	1	3
Department of Agriculture, Environment and Rural Affairs	1	8	3	2	1	3
Department of Education	2	1	1	2	0	0
Department of Finance	0	7	5	1	0	1
Department of Finance - Land & Property Services	1	11	5	6	0	1
Department of Justice	0	3	2	0	0	1
Department of Health	1	4	5	0	0	0
The Executive Office	1	1	1	0	1	0
Total	**19**	**143**	**87**	**42**	**8**	**25**

Housing

	Brought Forward @ 01/04/18	Complaints Received in 2018-19	Determined at Initial Assessment	Determined at Assessment	Determined at Investigation	Carried Forward @ 31/03/2019
Apex Housing	0	1	1	0	0	0
Choice Housing	0	10	5	3	0	2
Clanmil Housing Association Ltd	0	1	1	0	0	0
Habinteg Housing Association (Ulster) Ltd	0	1	0	1	0	0
Northern Ireland Housing Executive	7	54	36	15	4	6
Radius Housing	0	7	5	2	0	0
Total	**7**	**74**	**48**	**21**	**4**	**8**

Local Councils

	Brought Forward @ 01/04/18	Complaints Received in 2018-19	Determined at Initial Assessment	Determined at Assessment	Determined at Investigation	Carried Forward @ 31/03/2019
Antrim & Newtownabbey Borough Council	1	6	3	3	0	1
Ards & North Down Borough Council	3	5	1	6	0	1
Armagh City, Banbridge & Craigavon Borough Council	2	10	7	1	0	4
Belfast City Council	2	15	10	5	1	1
Causeway Coast & Glens Borough Council	1	7	4	2	1	1
Derry City & Strabane District Council	1	7	6	0	1	1
Fermanagh & Omagh District Council	1	4	3	2	0	0
Lisburn & Castlereagh City Council	3	3	3	3	0	0
Mid & East Antrim Borough Council	2	11	6	5	1	1
Mid Ulster District Council	0	5	2	3	0	0
Newry, Mourne & Down District Council	8	3	0	5	4	2
Total	**24**	**76**	**45**	**35**	**8**	**12**

Education

	Brought Forward @ 01/04/18	Complaints Received in 2018-19	Determined at Initial Assessment	Determined at Assessment	Determined at Investigation	Carried Forward @ 31/03/2019
Queen's University Belfast	2	11	4	7	0	2
Ulster University	1	5	2	4	0	0
Belfast Metropolitan College	0	1	0	1	0	0
College of Agriculture, Food & Rural Enterprise	0	2	2	0	0	0
Education Authority	0	17	12	5	0	0
South Eastern Regional College	0	1	1	0	0	0
Board of Governors of Nursery School	1	1	1	1	0	0
Board of Governors of Grammar School	0	7	1	4	0	2
Board of Governors of Primary School	11	29	11	17	0	12
Board of Governors of Secondary School	5	14	6	8	0	5
Board of Governors of Special School	1	2	1	2	0	0
Total	**21**	**90**	**41**	**49**	**0**	**21**

Public Services Ombudsmen
Principles for Remedy

This is a guide to explain how Public Services Ombudsmen in the United Kingdom and Ireland (the Ombudsmen[1]) aim to put things right for members of the public who have suffered injustice or hardship resulting from maladministration or poor service by a public body in their jurisdiction. This guide outlines the Ombudsmen's general approach to recommending remedy for injustice and is based on the PHSO Principles for Remedy. In setting out six guiding Principles for Remedy, the aim is to achieve a consistent approach to remedy by the Ombudsmen. It is important that both members of the public and public service providers in jurisdiction are aware of how decisions on an appropriate remedy for injustice resulting from maladministration have been arrived at in any case. These Principles for Remedy are an agreed framework for the Ombudsmen to reference in order to inform, where appropriate, their approach to remedy.

What do we mean by remedy?

Identifying and where possible remedying an injustice or hardship caused by a body's maladministration or poor service is a key function of an Ombudsman. Members of the public when making a complaint to an Ombudsman are invited to identify the remedy or outcome they seek. This is important so that the Ombudsman can decide whether or not an alternative legal remedy exists for the injustice complained of, as there may be a more appropriate course of action for the complaint to pursue. Ombudsmen offer a flexible range of potential non-judicial remedies that can be applied in any case. Ombudsmen remedies can include but are not limited to:

- an apology
- an explanation
- correction of an error
- an agreement to change practices, procedures or systems
- financial redress

How can this guide be used by Ombudsmen?

It is a matter for each of the Ombudsmen to decide on an appropriate remedy based on the identified maladministration and injustice suffered by the individual in any case. This guide is not intended to limit the Ombudsmen in the exercise of their discretion in any particular case.

1 In this document, Ombudsman and Ombudsmen are to read as interchangeable.

The Ombudsmen's Principles for Remedy are intended as an agreed normative framework to inform their approach to remedy where public services have been found to have failed and also as a reference point for Ombudsmen when developing more detailed guidelines relevant to their particular legal framework.

The Principles

Principle 1: To Put things right

The overarching principle when considering a remedy for injustice is to restore the individual back to the position they were in prior to the maladministration or poor service taking place. That may include recommending the award of the benefit to which the individual was entitled but had not received because of the failings of the public body concerned. Or recommending payment for a loss suffered as a result of the maladministration. Ombudsmen may also recommend payments for upset or 'time and trouble' where appropriate.

However, the outcome of maladministration or poor service cannot always be rectified or circumstances reversed. In such cases by offering a particular remedy the Ombudsman seeks to, at the very least, remedy the injustice sustained by the individual.

In a particular case 'Putting things Right' may also require a consideration of remediation for the public in general. In cases where the maladministration affects more than one individual because systemic failings have been identified, the Ombudsman will seek to remedy this by making recommendations in the public intere st for systemic change.

Putting things right might also involve an Ombudsman drawing the attention of the relevant governing body (Parliament, Assembly, or full council of the relevant local authority) to a specific legislative failing which has resulted in an injustice.

Principle 2: To be open and accountable

The Ombudsman should be open and clear about the reasons why they have recommended a certain type of remedy. This includes publishing on their website their specific policies on remedy and providing detail of the injustice they are seeking to address by their recommendation as well as explicit reasons for that recommendation in their report to the body and complainant.

Where a body fails to comply with a recommendation this will be reported openly and publicly to the relevant Parliament, Assembly or full council of the relevant local authority, so that the public body is accountable for its actions.

To enable public bodies to be aware of Ombudsmen's recommendations for remedy in particular cases, these will be reported on in an annual report and case digest which will be published.

Principle 3: To be empowering

The Ombudsman will, take into account the views and circumstances of the complainant and consider what remedy they are seeking. In addition, where appropriate the Ombudsman will consider the views of the complainant in relation to the issue of remedy. However, at the outset the Ombudsman should manage the expectations of a complainant regarding remedy and redress, and what can be achieved as ultimately, the Ombudsman will decide what is an appropriate remedy, within the scope of his/her remit, in any particular case.

Principle 4: To be fair, reasonable and consistent

The Ombudsman will treat each case on its own merits and consider the specific circumstances of each case, ensuring that the remedy recommended is reasonable once all aspects of the injustice have been considered.

Ombudsmen may delegate decision making to staff in their offices in relation to recommending a remedy in certain cases. However, Ombudsmen will ensure that in deciding on an appropriate remedy, there is consistency with previous decisions and also a consistency in approach in reaching a decision about what is an appropriate remedy. In the case of a recommendation for financial redress, consistency does not refer to the monetary amount offered for a particular type of complaint. Where the Ombudsman is recommending financial redress and as no two complaints are ever exactly the same, the Ombudsman will consider carefully the nature of the injustice sustained and whether it is possible to put the person back in the position they would have been in but for the maladministration or service failure identified.

The Ombudsman will seek to be fair and act without bias or prejudice in addressing individual cases for remedy. To ensure a fair process the Ombudsman will indicate to both the complainant and the public body in advance of a final report on an investigation his/her considerations for remedy (in draft form) and will consider the parties views. Although ultimately the final recommendation is a matter for the Ombudsman.

Principle 5: To be proportionate

The Ombudsman will recommend an appropriate remedy which is fair and proportionate in all the circumstances and having particular regard to the nature of the injustice caused to the complainant by the maladministration or poor service.

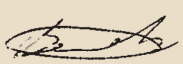
Principle 6: To monitor and ensure compliance

Public Service Ombudsmen have powers to bring to the attention of their legislature (that is Parliament or Assembly or the full council of the relevant local authority) where a recommendation has not been met by the body. This is an important function of an Ombudsman as it is to the relevant legislative or governing body that he or she must report the failings in such circumstances. This in turn requires an Ombudsman, as a matter of good practice, to check routinely with public service providers to ensure that a recommendation has been fully complied with. Failure to comply with an Ombudsman's recommendation may be the subject of a 'special report' by the Ombudsman to the relevant legislature or governing body as this failure can constitute maladministration.

Signed
Public Services Ombudsmen

8 March 2018.

Marie Anderson **Date**
Northern Ireland Public Services Ombudsman



8/3/18

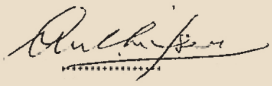
Nick Bennett **Date**
Public Services Ombudsman for Wales

8/3/2018

Peter Tyndall **Date**
Ombudsman & Information Commissioner for Ireland

8th March 2018

Oillp Dayaram Tirathdas **Date**
Ğibraltar Public Serv ices Ombudsman



8/3/2018

Anthony Mifsud **Date**
Parliamentary Ombudsman • Malta

A Keeney 21.5.19

Andrea Keeney **Date**
Housing Ombudsman Interim

Rob Behrens 8 March 2018

Rob Behrens **Date**
Parliamentary & Health Services Ombudsman

8 March 2018

Mick King **Date**
Local Government Ombudsman-&
Chair of the Commission for Local Administration in England

Rosemary Agnew 8 March 2018.

Rosemary Agnew **Date**
Scottish Public Services Ombudsman

Appendix 3
List of Public Authorities Within Remit of the Northern Ireland Public Services Ombudsman

Northern Ireland Assembly

- Assembly Commission
- The Independent Financial Review Panel

Northern Ireland Departments

- A Northern Ireland department

Local Government

- A district council
- The Local Government Staff Commission for Northern Ireland
- The Northern Ireland Local Government Officers' Superannuation Committee

Education and Training

- The board of governors of a grant-aided school
- An industrial training board
- An institution of further education
- The General Teaching Council for Northern Ireland
- The Northern Ireland Council for Postgraduate Medical and Dental Education
- The Northern Ireland Council for the Curriculum, Examinations and Assessment
- The Education Authority
- University of Ulster
- The Queen's University of Belfast
- The Youth Council for Northern Ireland
- The Council for Catholic Maintained Schools

Policing, Criminal Justice and Law

- A policing and community safety partnership or a district policing and community safety partnership
- The Northern Ireland Policing Board
- The Chief Inspector of Criminal Justice in Northern Ireland
- The Commission for Victims and Survivors for Northern Ireland
- The Northern Ireland Police Fund
- The Probation Board for Northern Ireland
- The Royal Ulster Constabulary George Cross Foundation
- The Northern Ireland Law Commission
- The Police Rehabilitation and Retraining Trust

Arts and Leisure

- The Arts Council of Northern Ireland
- The Board of Trustees of the National Museums and Galleries of Northern Ireland
- The Northern Ireland Library Authority
- The Northern Ireland Museums Council
- The Northern Ireland Tourist Board
- The Sports Council for Northern Ireland

Health and Social Care

- A health and social care trust
- A special health and social care agency
- The Northern Ireland Practice and Education Council for Nursing and Midwifery
- The Health and Social Care Regulation and Quality Improvement Authority
- The Northern Ireland Social Care Council
- The Patient and Client Council
- The Regional Agency for Public Health and Social Well-being
- The Regional Health and Social Care Board
- The Regional Business Services Organisation
- A general health care provider
- An independent provider of health and social care

Investment and Economic Development

- Invest Northern Ireland
- The company for the time being designated under Article 5 of the Strategic Investment and Regeneration of Sites (Northern Ireland) Order 2003
- A development corporation established under Part III of the Strategic Investment and Regeneration of Sites (Northern Ireland) Order 2003

Industrial Relations

- Office of the Certification Officer for Northern Ireland
- The Labour Relations Agency

Harbours

- The Northern Ireland Fishery Harbour Authority
- A harbour authority within the meaning of the Harbours Act (Northern Ireland) 1970

Housing

- A registered housing association within the meaning of Article 3 of the Housing (Northern Ireland) Order 1992
- The Northern Ireland Housing Executive

Children and Young People

- The Safeguarding Board for Northern Ireland
- The Office of the Commissioner for Children and Young People for Northern Ireland

Charity and Voluntary Sector

- Regulator of Community Interest Companies
- Appeal Officer for Community Interest Companies
- The Charity Commission for Northern Ireland
- The Northern Ireland Community Relations Council

Miscellaneous

- The Agri-Food and Biosciences Institute
- Civil Service Commissioners for Northern Ireland
- The Comptroller and Auditor General
- The Equality Commission for Northern Ireland
- The General Consumer Council for Northern Ireland
- The Health and Safety Executive for Northern Ireland
- The Livestock and Meat Commission for Northern Ireland
- The Northern Ireland Audit Office
- The Northern Ireland Authority for Utility Regulation
- The Northern Ireland Fire and Rescue Service Board
- The Office of the Commissioner for Older People for Northern Ireland
- Ulster Sheltered Employment Limited
- A new town commission established under the New Towns Acts (Northern Ireland) 1965 to 1968
- An implementation body to which the North/South Co-operation (Implementation Bodies) (Northern Ireland) Order 1999 applies

Notes

Northern Ireland
Public Services
Ombudsman

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