Investigation Report

Investigation of a complaint against the South Eastern Health & Social Care Trust

NIPSO Reference: 202000294

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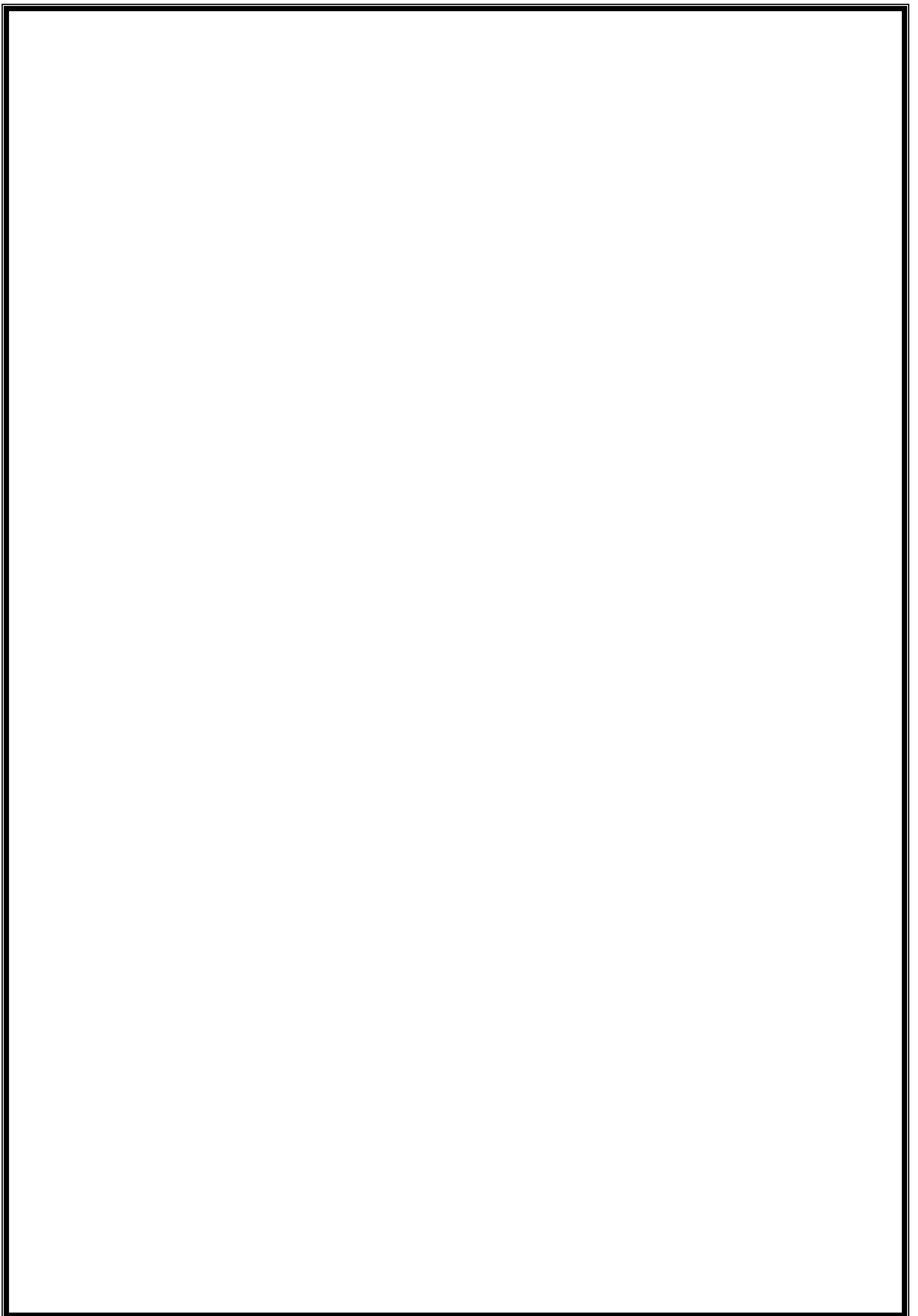

The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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Appendix 1 – The Principles of Good Administration
Appendix 2 – The Principles of Good Complaints Handling

Case Reference: 202000294

Listed Authority: South Eastern Health & Social Care Trust

SUMMARY

I received a complaint about the care and treatment the South Eastern Health and Social Care Trust (the Trust) provided to the complainant on 20 April 2020. The complainant said that the Trust did not take her requests for an epidural into consideration during her labour, and did not take her mental health into consideration. The complainant said that as a result of the care and treatment the Trust provided to her on 20 April 2020, she now suffers severe anxiety and flashbacks.

The investigation examined the details of the complaint, the Trust's response, clinical records, and relevant guidance. I obtained advice from three Independent Professional Advisors who have experience in midwifery, obstetrics, and perinatal mental health.

The investigation established that there were failings by the Trust in the care and treatment provided to the complainant on 20 April 2020. The investigation established that the Trust failed to provide an epidural to the complainant at the earliest opportunity during her labour in accordance with her agreed plan and failed to respond to requests for one during her labour until it was too late for one to be provided.

As a result the complainant did not receive an epidural. The investigation also established that the Trust were aware of the complainants mental health history but failed to take action in order to relieve her anxieties and distress. This could have been achieved by providing the complainant with an epidural and moving her to the labour ward as early as possible so that she could benefit from the support of her husband as due to COVID 19 restrictions birthing partners were only permitted in the labour ward. As a result the complainant had a distressing labour which subsequently affected her mental health to the extent that she required medication and counselling

I recommended that the Trust apologise to the complainant for the failures identified. I also recommended actions for the Trust to undertake to prevent the failures recurring.

THE COMPLAINT

1. I received a complaint about the care and treatment South Eastern Health and Social Care Trust (the Trust) provided to the complainant on 20 April 2020. The complainant raised concerns about how the Trust handled her request for an epidural, and also raised concerns about how the Trust took her mental health into consideration.

Background

2. On 4 February 2020, the complainant met with an Obstetrician and discussed that she had a lot of anxiety surrounding her upcoming labour. The complainant was noted to have a history of mental health illness, and so it was agreed that the complainant was to be induced ten days before her due date in order to receive an epidural during her labour which would help relieve some of her anxiety.

3. On 20 April 2020 the complainant attended Ulster Hospital for the induction of labour. A Propess pessary[1] was issued to the complainant to induce her labour at 12.45.

4. The complainant's labour progressed rapidly between 18.55 and 21.50. It is documented within the complainant's medical records that there was a delay in obtaining a blood sample from the complainant, which led to a delay in the complainant being administered an epidural. The complainant's medical records document that when her blood results were received, the anaesthetist was contacted. However, when seen by the anaesthetist at 22.00, the complainant was soon noted as actively giving birth, and it was too late for an epidural to be sited.

Issue of complaint

5. The issue of complaint accepted for investigation was:
   Whether the patient received care and treatment in relation to her labour on 20 April 2020 in accordance with relevant guidelines and standards.

[1] A prostaglandin drug used to ripen the cervix and start labour

INVESTIGATION METHODOLOGY

6. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues raised by the complainant. This documentation included information relating to the Trust's handling the complaint.

Independent Professional Advice Sought

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

   - A practising Midwife (MW IPA), RM RN BSc (HONS) PgCERT MA. (MW IPA)
   - Consultant Obstetrician (O IPA) with subspecialist accreditation in Fetal and Maternal Medicine, PHD MRCOG. The IPA works in a busy teaching hospital providing antenatal, intrapartum and postpartum medical care to low and high-risk women (O IPA).
   - Practitioner Psychologist, CPsychol, CMgr, FCMI, FHEA, AFBPsS, CBP, MISCP, EuroPsy HCPC-registered Practitioner Psychologist. The IPA has over ten years' experience as a clinician, including training and clinical practice in a perinatal mental health service (MH IPA).

   The clinical advice received is enclosed at Appendix three to this report.

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

Relevant Standards and Guidance

9. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the

circumstances of the case. I also make reference to relevant regulatory, professional and statutory guidance.

The general standards are the Ombudsman's Principles[2]:

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

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

The specific standards and guidance relevant to this complaint are:

- National Institute for Health and Care Excellence CG190 Intrapartum Care for Healthy Women and Babies (2014, updated 2017 (NICE CG 190);
- National Institute for Health and Care Excellence CE cg 70 Inducing Labour (2008, updated 2018) (NICE CG 70);
- Visiting Guidance Issued for Hospitals and Care Homes Department of Health 23 September 2020 (DoH Guidance); and
- National Institute for Health and Care Excellence Guidance Recommendations Recognising Mental Health Problems in Pregnancy and the Postnatal Period and Referral 11 February 2020 (NICE Mental Health Guidance).

11. I did not include all of the information obtained in the course of the investigation in this report but I am satisfied that everything that I consider to be relevant and important was taken into account in reaching my findings.

12. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations.

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

THE INVESTIGATION

Issue 1: *Whether the patient received care and treatment in relation to her labour on 20 April 2020 in accordance with relevant guidelines and standards.*

In particular this will consider:

- The patient's request for an epidural.
- Assessment and consideration of the patient's mental health.

Detail of Complaint

13. The issue of complaint is about the Trust's care and treatment of the complainant on 20 April 2020. The complainant said that:
    - she repeatedly asked for an epidural during labour and was told the reason she did not receive an epidural was because the midwives did not believe she was in labour;
    - that she was on her own during the induction as her husband was not allowed be with her until she was admitted to the labour ward;
    - she had a lot of anxiety surrounding the receipt of an epidural;
    - she suffered anxiety attacks during her labour, and was in a lot of distress;
    - Since the birth she has been reliving the nightmare every day. She suffers from flashbacks and severe anxiety due to her labour; and She believed that the midwives did not take her mental health seriously during her labour.

Evidence Considered

Legislation/Policies/Guidance

14. I considered the following policies/guidance:
    - NICE CG 190;
    - NICE CG 70;
    - DoH Guidance; and
    - NICE Mental Health Guidance.

Relevant extracts are enclosed at Appendix four to this report.

The Trust's response to investigation enquiries

Request for an epidural

15. The Trust said the complainant's labour was induced by the insertion of a Propess pessary, and during a vaginal assessment at 18.55, it was identified that the cervix had dilated 0.5cm in just over six hours. The Trust said the medical team made a decision to *'insert a Foley catheter[3] to ripen the cervix in preparation for labour'*. The Trust stated, *'in retrospect, despite the findings of the vaginal examination, she may have been in labour or the insertion of the Foley catheter may have led to labour commencing'*.

16. The Trust stated *'often the Anaesthetist requests that a woman's blood results be available prior to sitting an epidural. The Midwives are aware of this, and [the complainant's] blood should have been sent prior to [the complainant] going to labour ward'*. The Trust stated, *'currently there is no SET [South Eastern Trust] policy stating what bloods should be taken prior to siting an epidural in labour. This is left to the discretion of the attending* anaesthetist'. The Trust stated that had bloods been taken prior to the complainant being transferred to the Labour Ward, *'an epidural would most likely have been sited at an appropriate time and again we apologise that they were not taken earlier'*.

17. The Trust stated that at 21.50 the complainant's *'cervix confirmed to be 8cm dilated, it was too late for her to have an epidural and for this we apologise.'*

18. The Trust said the complainant's labour progressed rapidly between 18.55 and 21.50, and early transfer to the Labour Ward for epidural would *'most probably have provided [the complainant] with adequate pain relief and improved [the complainant's] birthing experience'*.

Assessment and Consideration of Mental Health

19. The Trust said the complainant's history of anxiety was clearly documented in the complainant's maternity records and a consultant note requested *'early*

[3] A Foley catheter is a soft, plastic or rubber tube that is inserted into the bladder to drain the urine.

epidural if possible'. The Trust stated, *'we deeply regret that [the complainant] feels she was ignored and her mental health was not taken seriously'*.

20. The Trust stated in the induction bay the Midwife reassured the complainant that she would *'examine [the complainant] more frequently to keep [the complainant's] mind at ease and to assess progress to enable [the complainant] to get an epidural in time'*.

21. The Trust stated *'between 19.05 and 19.30 hours, [the complainant] is noted to be 'very distressed' on three occasions. It was at this time preparation for transfer to the labour room was commenced. A further dose of Diamorphine as administered to [the complainant] whilst she was waiting for transfer to the Labour Ward.'*

22. The Trust stated, *'it is regrettable that due to Covid-19 guidelines, all mothers who attended the Induction Suite for induction of labour were unable to be accompanied by their birthing partners until their transfer to the Labour Ward. Earlier transfer to the Labour Ward would have enabled her birthing partner to be with [the complainant] and provide [the complainant] with the support she needed'*.

Relevant Trust records

23. The patient's clinical records were considered. Relevant extracts from the clinical records are enclosed at Appendix five to this report.

Relevant Independent Professional Advice

Midwife (MW) IPA

Request for an epidural.

24. The MW IPA advised that established labour is determined when the patient is having regular painful contractions about 3-4:10 minutes. The MW IPA referenced NICE CG 190 and NICE CG 70 and advised *'the woman should have been offered an epidural even though established labour had not been confirmed'*.

25. The MW IPA advised: *‘there were a number of missed opportunities to provide the woman with an epidural at an earlier time as had been planned.’* She referenced NICE CG 190 which states *‘if a woman in labour asks for regional analgesia, comply with her request. This includes women in severe pain in the latent[4] first stage of labour.’* The MW IPA advised *‘according to NICE guidelines it would have been appropriate for the woman to be offered an epidural at 15.10 hrs as she was now contracting regularly and there had been some small changes to her cervix and particularly noting the woman’s acute anxiety and wish for an epidural.’*

26. The MW IPA advised that at 18.55 it would also have been appropriate to transfer the complainant at this time to administer an epidural.

27. The Trust’s records document at 19.30 the complainant’s contractions were 3-4:10 minutes, and the notes say that the complainant was very distressed and requesting an epidural. The Trust’s records document the complainant was transferred to the delivery suite at 20.30. The MW IPA advised *‘this was a long time for [the complainant] to wait given that [the complainant] was distressed and contracting 3-4:10 minutes’*.

28. The MW IPA concluded that, *‘there were a number of missed opportunities to provide the woman with an epidural at an earlier time as had been planned’*. The MW IPA advised *‘it is the role of the midwife to request an epidural for the woman if this is her choice of pain relief’*.

Obstetrician (OB) IPA

29. The OB IPA advised that from NICE CG 190 and NICE CG 70 there is no reference to blood results being required prior to the administration of an epidural.

[4] Existing but not yet developed or manifest; hidden or concealed.

30. He also advised *'there are some clinical situations (e.g. pre-eclampsia[5]) where it would be established good practice to wait for the full blood count before administering an epidural, because the patients may have a low platelet level'*. The OB IPA advised however that he has not seen any evidence that the complainant had pre-eclampsia prior to her epidural being sited. He also had not *'seen any reason that the epidural could not have been administered to [the complainant] without blood results'*. However, the OB IPA advised that this may not be usual practice at the Trust.

31. The IPA concluded that the failing(s) were that either *'[the complainant] should have had her bloods taken sooner in the induction process or [the complainant] should have had an epidural sited without the need to await the blood results.'* The IPA recommended that the Trust review its local guidelines regarding epidural analgesia, in particular the area of whether blood results are required in every case where an epidural is to be sited.

Assessment and Consideration of Mental Health.

32. The MW IPA advised, *'overall the Trust did take into consideration the [complainant's] mental health, particularly her anxiety around the epidural in labour, and their actions were intended to support the woman. However, there is no documentation around ongoing monitoring of the woman's mental health by the midwives during the antenatal period which may have indicated that a referral to the Perinatal Mental Health team would have been beneficial'*.

33. The MW IPA advised that the complainant was admitted into hospital during the peak of the Covid19 pandemic. She advised *'it was therefore reasonable to prevent her husband from attending during the induction.'*

Perinatal Mental Health (MH) IPA

34. The MH IPA advised that during the initial assessment the Trust's documentation states that the Trust staff were aware of the complainant's mental health history and the consultant's request for an early epidural if possible. The MH IPA advised *'there is no indication in the medical notes that*

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[5] A condition that causes high blood pressure during pregnancy and after labour.

the Trust staff considered the possible risk or presence of postnatal post-traumatic stress.' The MH IPA also advised *'had they had done so, they may have been able to offer some advice on how to deal with this after discharge'*.

35. The MH IPA advised *'there was substantial pre-existing and contemporaneous evidence to suggest that an early epidural was justified on the grounds of mental health.'* The MH IPA advised *'the absence of an epidural resulted in the patient experiencing considerable distress and pain. The failure to address the patient's anxiety (that an epidural would not be administered in time) meant that the patient's anxiety grew as the labour progressed and the window of opportunity to administer an epidural began to close.'* The IPA advised *'as a result [the complainant] experienced a traumatic labour which is likely to have contributed to subsequent mental health difficulties.'*

36. The IPA recommended the Trust plan ahead for an epidural, take into account a patient's full mental health history and be proactive following a traumatic labour. Full details on these recommendations are enclosed at Appendix three to this report.

Analysis and Findings

Request for an epidural.

37. The complainant said that she did not receive an epidural despite her requests for one. The NICE CG 190 states *'latent first stage of labour – a period time, not necessarily continuous, when there are painful contractions and there is some cervical change, including cervical effacement[6] and dilation up to 4 cm'*. The Trust records document at 15.10 that a vaginal examination was undertaken and it was documented that the complainant's cervix was two centimetres dilated and contracting 3-4:10 minutes. I accept the MW IPA's advice that *'according to NICE guidelines it would have been appropriate for the woman to be offered an epidural at 15.10 hrs as she was now contracting regularly and there had been some small changes to her cervix'*. I also accept the MW IPA's advice that it would also have been appropriate for the midwives to transfer the complainant to the labour ward at 18.55 to give her an epidural.

[6] Effacement is the shortening and thinning of the cervix.

38. NICE CG 190 states: *'If a woman in labour asks for regional analgesia, comply with her request. This includes women in severe pain in the latent first stage of labour.'* NICE CG 70 states in relation to pain relief during induction: *'During induction of labour, healthcare professionals should provide women with the pain relief appropriate for them and their pain. This can range from simple analgesics to epidural analgesia.'* The MW IPA also advised that *'it is the role of the midwife to request an epidural for the woman if this is her choice of pain relief'*. I accept the MW IPA's advice that *'there were a number of missed opportunities to provide the woman with an epidural at an earlier time as had been planned.'*

39. NICE CG 190 does not make reference to blood results being required prior to admission of an epidural. I note the OB IPA advised that *'there are some clinical situations (e.g. pre-eclampsia) where it would be established good practice to wait for the full blood count before administering an epidural'*. The OB IPA advised that the Trust's medical records do not document that the complainant had pre-eclampsia prior to her epidural being sited.

40. I refer to the OB IPA's advice, who advised, *'I have not seen any reason that the epidural could not have been administered to the patient without blood results. However this may not be usual practice at the Trust'*. I accept the OB IPA's advice that *'the failing(s) were that either 1. [the complainant] should have her blood taken sooner in the induction process, or [the complainant] should have had an epidural sited without the need to await the blood results.'* I refer to the Trust's response to NIPSO enquires which it stated, *'often the Anaesthetist requests that a woman's blood results be available prior to sitting an epidural.'* I consider that the midwives were aware of the complainant's desire to have an epidural sited, and her anxiety of missing an opportunity to receive an epidural. As the midwives were aware of the complainant's request, the midwives should have consulted with the Anaesthetist whether he required a blood sample. I consider the delay in obtaining a blood sample from the complainant led to a delay in her opportunity to receive an epidural. I consider if

a blood sample was obtained at an earlier point, the complainant would have received an epidural as requested.

41. I refer to the human rights principles of Fairness, Respect, Equality, Dignity and Autonomy (FREDA). I consider that the Trust failed to meet the principle of Autonomy. This principle allows a person to make free choices about what happens to them, and has the freedom to decide those choices. I consider that whilst the Trust was aware of the complainant's request to receive an epidural, the Trust missed a number of opportunities to provide the complainant with an epidural. I consider the Trust did not adhere to the FREDA Principle of Autonomy, and consider this is a failure in the complainant's care and treatment. For these reasons, I uphold this element of the complaint.

Assessment and consideration of mental health.

42. The complainant said that she was alone whilst she was induced, and her husband was only allowed to join her when she was admitted to the labour ward. The DoH Guidance states that a partner is able to accompany the patient when the patient is in active labour. I note that the complainant attended the hospital for the birth of her child during the peak of the Covid 19 pandemic, and accept the MW IPA's advice *'the advice was very clear about reducing the number of people accessing maternity departments and that partners should only be admitted to the unit once the woman was in established labour'*. I accept that the Trust acted in accordance with the Covid 19 regulations in place at that time.

43. The MW IPA advised that there were *'missed opportunities to have transferred the woman to labour ward to provide her with an epidural at an earlier time'*. I consider this failure to transfer the complainant to the labour ward at an earlier time denied the complainant time with her husband. As a result this had a negative impact on her mental wellbeing. As the Trust staff were aware of the Covid 19 regulations in place at that time, I did not find evidence within the Trust's documentation that the midwives considered the positive impact on the complainant's mental wellbeing if she was admitted earlier to the labour ward. I consider that because there was an earlier opportunity to transfer the

complainant to the labour ward, and the complainant's mental health was not taken into consideration regarding this issue, I uphold this element of the complaint.

44. The complainant said that the midwives did not take her mental health into consideration during her labour on 20 April 2020. NICE CG 190 states *'when performing an initial assessment of a woman in labour, listen to her story and take into account her preferences and her emotional and psychological needs.'* NICE CG 190 also states, *'give ongoing consideration to the woman's emotional and psychological needs, including her desire for pain relief'*, and to *'continue to take the woman's emotional and psychological needs into account'*.

45. The Trust's records indicate that during the initial assessment of the complainant, staff were aware of the complainant's mental health history and the consultant's request for an early epidural if possible. The Trust's records document that the midwives caring for the complainant following the induction and during labour both documented that they were aware of the complainant's anxiety around the epidural and had additional notes around a more personalised plan of care to accommodate this.

46. I accept the MH IPA's advice that although it was documented that the Trust staff were aware of the complainant's mental health history, and reassured her that she would receive the epidural *'this promise was not supported by the necessary action i.e. requesting the blood tests which the anaesthetist would require for the epidural'*. While it is clear midwifes were aware of the complainants anxiety, however there is no evidence in their actions that they took steps to alleviate this anxiety. This could have been achieved by listening to and understanding the complainant's wishes, providing the epidural as early in labour as possible and moving the complainant to the labour ward at the earliest opportunity so that she could benefit from the support of her husband. I am concerned that there is no evidence of person centre care in the complaints experience.

47. The MH IPA advised that during the postnatal stage *'there is some evidence that the patient's psychological state was assessed'*. However I accept the

IPA's advice that there is no evidence within the Trust's documentation that *'the staff recognised the labour as a traumatic. As a result, there is no indication in the medical notes that the Trust staff considered the possible risk or presence of postnatal post-traumatic stress (PTS)'*. I accept the MH IPA's advice that this would have been appropriate given the complainant's mental health history, and the traumatic nature of the childbirth.

48. I accept the MH IPA's advice that *'there was substantial pre-existing and contemporaneous evidence to suggest that an early epidural was justified on the grounds of mental health'*.

49. I note the Trust's medical records state on the complainant's discharge notes she was advised by the midwife to contact her GP regarding her 'mood'. The complainant said three weeks following her labour her health visitor referred her to a counsellor, and after four months her GP had prescribed her with anti-depressants.

50. I considered all the evidence available to me, and consider that whilst the Trust were aware of the complainant's mental health history, it failed to take action to relieve the complainant's anxiety and distress. For this reason I uphold this element of the complaint.

Injustice

51. I considered whether the failings I identified caused an injustice to the complainant. I found that the Trust had a number of opportunities to provide the complainant with an epidural which was her expressed wish, yet they failed to do so. The complainant's requests for an epidural were also ignored I consider that the complainant suffered the injustice of loss of opportunity to have pain relief provided at an appropriate time, and accept the MH IPA's advice that *'the absence of an epidural resulted in the patient experiencing considerable distress and pain'*.

52. I found that the Trust did not appropriately take into consideration the complainant's mental health during her time within the hospital, and failed to take action in order to relieve her anxieties and distress. I consider that the

complainant suffered an injustice of distress and anxiety. I accept the MH IPA's advice that *'every indication is that it was a very traumatic experience for the patient'*. I also accept the advice of the MH IPA that *'the patient experienced a traumatic labour which is likely to have contributed to subsequent mental health difficulties.'*

CONCLUSION

53. I received a complaint about the Trust from the complainant about the care and treatment provided to the complainant on 20 April 2020. The complainant said the Trust did not take into consideration her request for an epidural and subsequently she did not receive an epidural in time when giving birth. The complainant suffered severe stress and anxiety as a result of not receiving an epidural. The complainant has received counselling and anti-depression medication post labour.

54. The investigation established that the Trust failed to provide the appropriate care and treatment to the complainant by denying to provide her with an epidural upon her request. The investigation also established that the Trust staff were aware of the complainant's mental health history, but failed to take action in order to relieve her anxiety and distress by providing an epidural as early as possible and failing to move her to the labour ward at the earliest opportunity so that she could benefit from the support of her husband..

55. It is clear that the complainant's labour was a difficult event which caused her a great deal of distress and anxiety. We hope that our recommendations and findings contained within this report provide some closure to her.

Recommendations

56. I recommend within **one** month of the date of this report the Trust:
    i. Provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused to her as a result of the failures identified;
    ii. Ensure that all midwives involved in the complainant's care have the opportunity to reflect on their role in the patients labour and discuss it

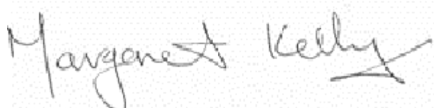
as part of their next appraisal focusing on how they can improve their practice in the future; and

iii. Review its local guidelines regarding epidural analgesia, in particular the issue of whether blood results are required in every case when an epidural is to be sited.

57. I recommend the Trust carry out a random sampling audit of patients' who requested an epidural during their labour, with a particular emphasis on whether the patient had received an epidural as requested, and take action to address any identified trends or shortcomings. I recommend the Trust advises this Office on the outcome of this audit including any recommendations or improvements in the practices within **six** months of the date of my final report.

58. I further recommend that the Trust reflect on the learning and service improvement recommended by the MW IPA, OB IPA and the MH IPA enclosed in Appendix three to this report. I would ask the Trust to reflect on the lack of person centred care provided to the complainant and whether this is indicative of a wider systemic issue.

59. I recommend that the Trust implements an action plan to incorporate these recommendations and should provide me with an update within **three** months of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies).



Margaret Kelly
Ombudsman **May 2022**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

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

6. Seeking continuous improvement

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

Appendix 2

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

- Publishing service standards for handling complaints.

- Providing honest evidence-based explanations and giving reasons for decisions.

- Keeping full and accurate records.

4. Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.

- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.

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

- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.

- Acting fairly towards staff complained about as well as towards complainants

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.

- Providing prompt, appropriate and proportionate remedies.

- Considering all the relevant factors of the case when offering remedies.

- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

6. Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.

- Having systems in place to record, analyse and report on learning from complaints.

- Regularly reviewing the lessons to be learnt from complaints.

- Where appropriate, telling the complainant about the lessons learnt and the changes made to services, guidance or policy.