Northern Ireland
Public Services
Ombudsman

Ombudsman's Report

2017 | 2018

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REPORT

of the

Northern Ireland
Public Services Ombudsman

2017-18

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

Contents

Foreword from the Ombudsman

Introduction

I am pleased to present the second general report on the work of my Office, the Northern Ireland Public Services Ombudsman.

As Ombudsman, I investigate complaints of maladministration in respect of listed authorities which provide a wide range of public services in Northern Ireland. I also investigate complaints of failings in professional judgment in health and social care.

Complaints activity

During 2017-18 contact with my Office increased by **37%**. I accepted a total of 665 complaints, which was an increase of **23%** from the previous year.

The increase is partly due to the fact that at the beginning of this reporting year complaints about the actions of Boards of Governors of all publicly funded schools came into my jurisdiction. Unlike the trend in respect of complaints about further and higher education institutions, school related complaints were more than double the number anticipated.

My senior staff engaged with Boards of Governors to inform them about my role and the Principles of Good Complaint Handling. I met with the Chief Executive and senior management team of the Education Authority to explain my role in the investigations of complaints. My staff, working with complaints handling staff, have also assisted in the development of a new complaints process for schools.

My Office is structured to ensure that when complaints are received, where possible they are resolved at an early stage. The ASSIST (Advice, Support Service and Initial Screening Team) performs an essential 'triaging' role for all complaints, enabling a speedy resolution of a complaint. We have been working hard to increase the number of cases resolved by a 'settlement'. I am pleased to report that there was an increase from **11** settlements in 2016-17 to **49** in 2017-18.

The Human Rights based approach to investigations, which I introduced in 2016, has continued to receive acclaim. This approach, which seeks to ensure that our work is rooted in protecting individuals and in assisting bodies to effectively apply human rights principles, is now firmly embedded within my Office. An example of how this approach is applied can be found in the case summary on page 31.

Public reports

The new power to publish reports in the public interest was first implemented during the year. This has provided me with the opportunity to raise awareness of my role as an independent and impartial investigator of complaints, as well as informing the public of cases where maladministration or service failure has occurred.

Publication of investigation reports demonstrates to public service providers how they can learn from complaints and plays an important role in delivering transparent public services.

My first public report (summarised on page 30) was published in February 2018. It concerned the case of the former Department of Environment and found maladministration in how it monitored an agreement on late flights with Belfast City Airport. I recommended the creation of guidance for Departmental staff to assist in their monitoring of late night flights. I am pleased to report this has now been developed.

Own Initiative power

During 2017-18 preparations also began for the new own initiative power which was provided for in section 8 of the Public Services Ombudsman Act (Northern Ireland) 2016. Two new senior investigations staff were recruited for this purpose, and together with my Deputy and the Director of Investigations they have developed criteria and outline methodologies for own initiative investigations.

Complaints Standards Authority

Part 3 of the 2016 Act also provides for me as Ombudsman to undertake the functions of a Complaints Standards Authority (CSA), enabling my Office to develop and publish standard complaint handling principles. This when developed will apply to all public service providers in Northern Ireland. My staff have been engaging with complaints handlers across the public sector to better inform them of the CSA role.

The policy behind this role is to ensure a consistent set of standards and principles that the public can expect whenever they complain first to the public service provider. I believe there is a clear need for such a function. A common feature of complaints to my Office involve issues around complaints handling by public bodies. The function was first created in Scotland in 2010 and the Scottish Ombudsman's remit as the regulator of complaints handling across the public service has achieved notable improvements for the benefit of the public and the service provider.

Although Part 3 of the 2016 Act is yet to be commenced, I have in this year, with the support of the Assembly Commission staff, commenced important research on understanding public sector complaints processes in Northern Ireland. This work also involves capturing complainants' experiences of listed authorities.

Good Record Keeping

A recurring theme in my findings during this and other reporting years has been the issue of poor record-keeping by public service providers. The case summaries contained within this report show just a few examples of where my investigators have found that records to support decisions taken have either not been kept or are of poor quality.

The public have a right to expect that decisions taken by public officials have been properly considered. Appropriate records to evidence this are an essential part of good governance. During the coming year I will be working with the Information Commissioners Office and others to issue guidance on best practice in this area.

The Future

I am the first Public Services Ombudsman in the United Kingdom to have 'own initiative' powers. The 'own initiative' power is one which other Ombudsmen have enjoyed as a standard part of the ombudsmen 'toolkit' to support improvement in public services. I look forward to the commencement of this power in 2018-19 in order to investigate areas where I have a reasonable suspicion that there is systemic maladministration.

I also look forward to the publication by my Office of the research on complaints handling across the public sector. This will provide me with useful information about the complaints handling landscape in Northern Ireland and inform my Office's work in this area during 2018-19.

A key business objective for my Office is to support learning from complaints and improvements in public service delivery. This can be achieved by ensuring that strategic lessons from casework trends and findings are shared effectively with listed authorities and other oversight bodies. The publication of investigation reports, case digests and bulletins, and the development of other communications and engagement initiatives during 2018-19 will help achieve this aim.

Reflections

The continued upward trend of enquiries and complaints has placed unprecedented pressure on my staff as they cope with increased demand in an already constrained financial climate.

The contribution of my Office to improving public services has been brought into focus by the absence of a functioning Assembly. Without Assembly Committees or locally elected ministers holding public bodies to account, my Office will continue to play an increasingly important role in the scrutiny of public services.

The dominance of complaints about health care is a reflection of the experience of other public services ombudsmen who have a health jurisdiction. Around three quarters of all my investigations are health related with a significant number in recent years relating to deaths in hospital. We also continue to deal with a wide range cases brought to us by some of the most vulnerable members of society. Where I see areas of concern I will raise these with the Health Trusts and ensure that my recommendations for service improvements are achieved.

I will also continue to comment on other incidents of unfairness or injustice as a result of maladministration, while also reporting on instances of good practice. I am grateful for the way public authorities accept my decisions and implement the changes we ask for.

The previous three years have seen almost constant change and transition within my Office as a result of the new legislation and the increase in powers given to me as Ombudsman. I am grateful to my Deputy Mr Paul McFadden, my Senior Management Team and to all of my staff for helping to deliver these changes and placing the Office in the strong position it finds itself today.

Marie Anderson

MARIE ANDERSON
Northern Ireland Public Services Ombudsman

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

The ASSIST Team is the Office's first point of contact for members of the public. ASSIST dealt with **4,987** enquiries during 2017-18, a 37% increase from 2016-17.

A total of **665** of these were classed by the team as complaints warranting more detailed analysis. **584** (88%) of these complaints were resolved within ASSIST. The remainder (**81**) were passed to the Investigations Team for further investigation (see Section 3).

The table below shows the main reasons for closure of some of the other enquiries which come to the Office. These include that the issue was outside the Ombudsman's jurisdiction, the complaints procedure of the organisation was not fully completed, or that the complainant had the right to take the matter to court or tribunal. In many cases we also find that we need further information to properly assess the complaint. Sometimes it is not possible for us to take a matter forward if a complainant expects an outcome that we are unable to deliver.

Assessment outcomes 2017-18

Closure reason	
Outside jurisdiction	Our legislation says what we can and cannot accept as a complaint.
Premature complaints	These are cases which have not completed the authority's complaints process and have been brought to us too early.
Court or Tribunal action available	We will direct some complainants to other more appropriate methods of resolving their complaint.
More information needed from complainant	We will explain what is needed and re-open the case when the information is received.
More information needed from public body	We sometimes need more information to develop our understanding of the complaint

It is important that we tell complainants whether we have accepted their complaint as soon as possible. In 2017-18 in 95% of cases we gave an initial decision within 10 working days.

The decisions we take on whether a complaint should be investigated follows an assessment of all of the information. It is made following further consideration of all the information obtained against our '3Ps' policy. The key decision criteria which we apply are:

- Would it be **proportionate** to investigate?
- Will an investigation achieve a **practical** outcome?
- Is an investigation in the **public interest?**

Boards of Governors of schools

At the beginning of the reporting year the Boards of Governors of more than 1100 schools across Northern Ireland came within the Ombudsman's jurisdiction. This was a significant addition to the Ombudsman's remit, and follows on from Colleges of Further and Higher Education, and Universities coming into jurisdiction in the previous year.

ASSIST staff attended information sessions for Boards of Governors to inform them of the Ombudsman's role and remit and carried out outreach with other organisations in the schools sector. We received a significant number of enquiries and a total of 71 complaints about Board of Governors, which was a significant increase in the predicted numbers. This is an extensive and complex remit and ASSIST continues work to develop knowledge and understanding of this landscape.

Settlements

We can take a decision to resolve a complaint at Assessment without carrying out an investigation. This is described as a settlement and provides a speedy, effective and practical resolution of the complaint. We work with the complainant and the organisation to identify appropriate settlements. These may include more effective or timely service provision, an apology for failures in service, reimbursment of expenses incurred or an improvement in service provision. This year ASSIST achieved 49 settlements, an increase of over 300% on the previous year. In addition to providing speedy resolution, the focus on settlement plays an important role in ensuring the Ombudsman's investigative resources are effectively targeted on the most serious and intractable complaints.

The case summaries on the following pages provide examples of a number of these settlements, and reflect the varied nature of the complaints brought to the Office.

Settlement Case Summaries

South Eastern Regional College waives course fees following Ombudsman intervention

The Ombudsman was able to help a student who complained that he had been misinformed about the total cost of his college fees.

He began a Diploma in Automative Management in the South Eastern Regional College (SERC) in September 2015. The course fees were £552 for Year 1 and £450 for Year 2.

He stated that many of the other students on the course applied under an apprenticeship scheme which meant they didn't pay any fees, and that he was not made aware of this until the end of the first year. He believed he would have been eligible for the scheme. He also said that he was told the total cost was £552, and that he only found out later there would be fees for the second year of £450.

The Ombudsman found that the complainant was misinformed by the college about the total cost of the course. There was also evidence of poor record keeping, including whether or not he was told about the apprenticeship scheme.

The Ombudsman suggested to the college that it should waive the second year fees of £450. This was agreed. The student was happy with the settlement.

NIHE reimburses man whose car was stuck in rented garage

A man was unable to use his car because of outstanding repair works to his rented garage. In response to a proposal by the Ombudsman, the Northern Ireland Housing Executive agreed to reimburse the man his tax and insurance for the 43 days he was without his car, and to apologise for the way they had handled his complaint.

Southern Health Trust reimburses cost of lost wedding ring

The husband of a patient noticed that his wife's ring was missing three days after her admittance to hospital.

As she had not been accompanied by any family at the time, he was advised by the hospital to submit a claim for compensation. However he was told later that he would not be reimbursed as it was the patient's responsibility to declare valuables at the time of admission.

Following enquiries from the Ombudsman the Trust investigated the issue further and decided to reimburse the man £605 for the loss of the ring.

Department for Communities agrees not to pursue overpayment of income support

The complainant came to the Ombudsman after he was told in 2016 that he had been overpaid Income Support between April and July 2008. He added that he had been told by the Social Security Agency that they were unable to show how this overpayment had occurred because there were no records available.

He considered that it was unfair he was being asked to repay the money because of the 8 year delay, that there was no supporting evidence with the request, and that the length of time that had elapsed mean that he no longer had any right to appeal.

The Department for Communities agreed that it would not pursue the recovery of the debt and provided the man with a written apology.

GP Practice acknowledges failings

A complaint to the Ombudsman was settled when a GP Practice agreed to write to a complainant and acknowledge its failure to keep appropriate records in relation to an investigation of her 'confrontational' behaviour in the Practice.

Patient reimbursed for lost dentures by Belfast Health and Social Care Trust

The Ombudsman received a complaint from a patient that her dentures had been mislaid by a hospital while she was in theatre for an operation. She had complained to the hospital, but the Belfast Health and Social Care Trust did not accept liability for the loss.

Ombudsman staff contacted the Trust and explained why they believed reimbursement would be appropriate. The Trust then confirmed that they had re-considered their original decision and reimbursed the patient. They also apologized to the patient for the length of time she had spent pursuing the complaint and the upset it had caused her.

Settlement resolves complaint against Northern Ireland Housing Executive

The Ombudsman helped to resolve a complaint by a tenant who was unhappy about the length of time he had been on a housing waiting list.

Enquiries into the man's complaint revealed that there was no evidence of maladministration by the NIHE. However, the organisation was asked whether anything further could be done to assist the man. It was proposed that he would be contacted again for more discussions on suitable housing options, provided with a full review of all his circumstances, and given an enhanced explanation of how the decisions regarding his application had been reached.

Northern Regional College apologises after removal of autistic student's work during art display

The Ombudsman received a complaint from the mother of an autistic student whose artwork folder and sculpture were both moved behind a screen during an art display.

Attempts by the college and the complainant to resolve the complaint had failed.

Following enquiries by the Ombudsman, the Principal of the college accepted the failures over what happened, and agreed that they would issue an apology, contact the External Verifier to check on whether the artwork was observed, and conduct a review of procedures to prevent anything similar from happening again.

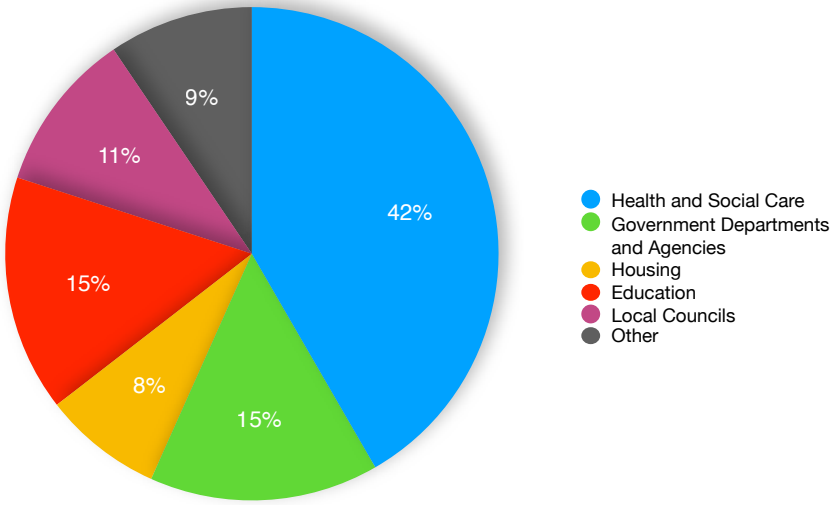
Section Two
Breakdown of complaints by sector

Analysis of Complaints

From the **4,987** contacts received by ASSIST in 2017-18, a total of **665** complaints were considered for further investigation. The complaints related to a wide range 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

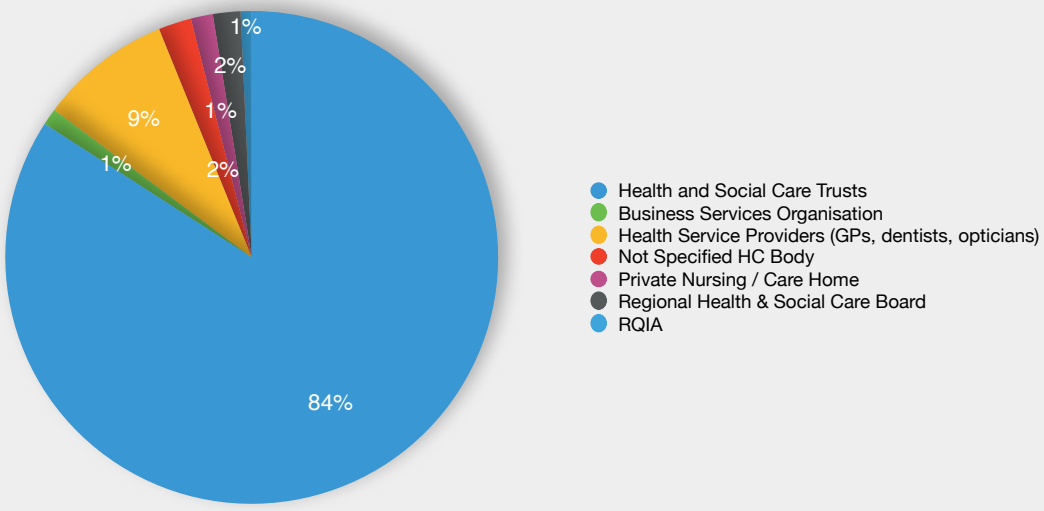
Percentage of Complaints by Sector 2017-18



Sector	Number of Complaints
Health and Social Care	277
Government Departments and Agencies	100
Education	103
Local Councils	70
Housing	52
Other	63
Total	**665**

Health and Social Care

42% of complaints related to Health and Social care.



Examples of complaints about the health care sector include issues around delays in care and treatment, misdiagnosis, poor communication with patients and their family members (for example in end of life cases), premature discharge from hospital, and complaints about the way a Serious Adverse Incident was carried out.

Within the Social Care sector common complaints include errors in social work reports, social care decisions during family break-up cases, care and treatment within a nursing home, and complaints about eligibility for continuing healthcare.

Total Complaints about Health and Social Care.

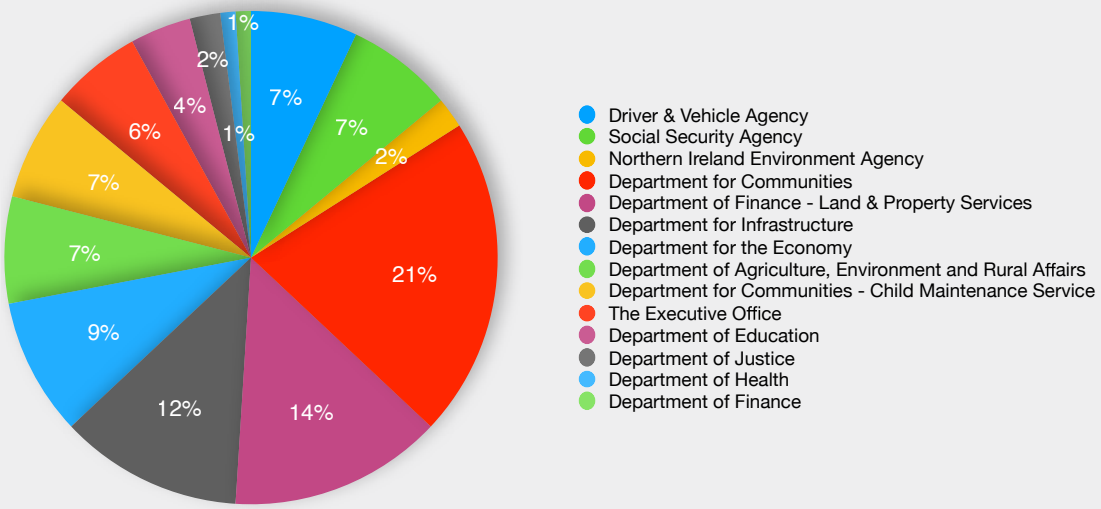
Health and Social Care Sector	Number of complaints
Health and Social Care Trusts	233
Health Service Providers (GPs, dentists, opticians, pharmacists)	24
Not Specified HC Body	6
Regional Health & Social Care Board	5
Private Nursing / Care Home	4
Business Services Organisation	3
RQIA	2
Total	**277**

Total Complaints about Health and Social Care Trusts

Trust	Number of complaints
Belfast Health & Social Care Trust	53
Northern Health & Social Care Trust	46
South Eastern Health & Social Care Trust	42
Southern Health & Social Care Trust	40
Western Health & Social Care Trust	40
South Eastern Health & Social Care Trust (Prison Healthcare)	9
Northern Ireland Ambulance Service Trust	3
Total	**233**

Government Departments and Agencies

15% of complaints related to Government Departments and Agencies.



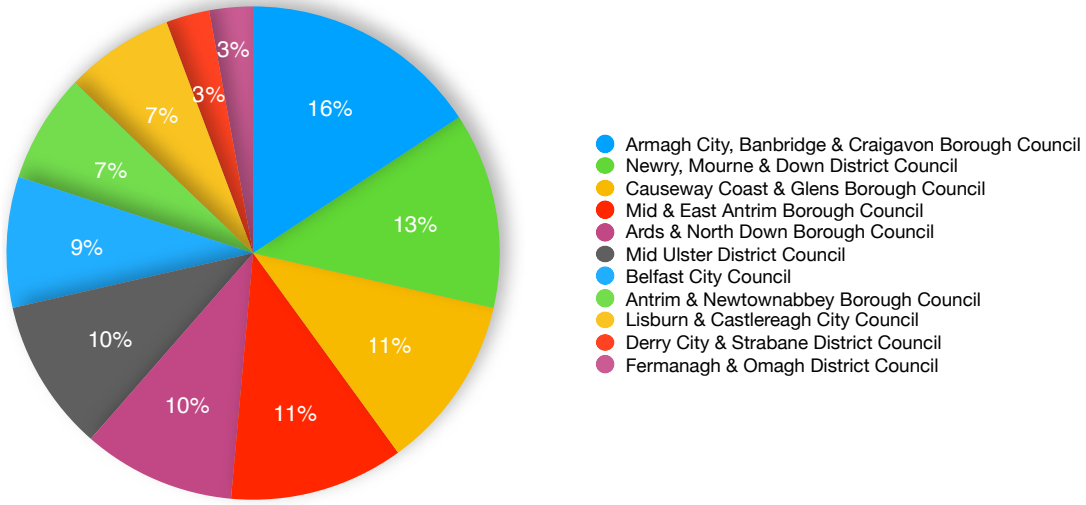
Examples of complaints about government departments include issues around the administration of PIPs (Personal Independence Payments), ESAs (Employment and Support Allowance) assessments, child support payments and Single Farm Payments. The public also raised concerns about the lack of enforcement action by Departments and their agencies.

Total Complaints about Government Departments and Agencies of Government Departments

Government Department or Agency	Number of Complaints
Department for Communities	21
Department of Finance - Land & Property Services	14
Department for Infrastructure	12
Department for the Economy	9
Department of Agriculture, Environment and Rural Affairs	7
Department for Communities - Child Maintenance Service	7
The Executive Office	6
Department of Education	4
Department of Justice	2
Department of Health	1
Department of Finance	1
Driver & Vehicle Agency	7
Social Security Agency	7
Northern Ireland Environment Agency	2
Total	**100**

Local Councils

11% of complaints related to Local Councils



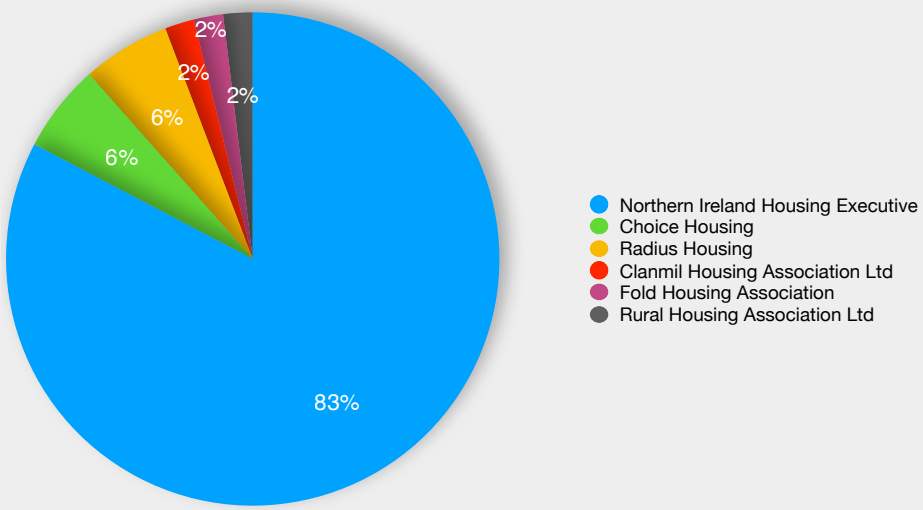
Examples of complaints about councils include concerns about planning decisions, the administration of local government procurement projects, and cases where no enforcement action was taken in relation to planning breaches and noise nuisance.

Total Complaints about Local Councils

Council	Number of Complaints
Armagh City, Banbridge & Craigavon Borough Council	11
Newry, Mourne & Down District Council	9
Causeway Coast & Glens Borough Council	8
Mid & East Antrim Borough Council	8
Ards & North Down Borough Council	7
Mid Ulster District Council	7
Belfast City Council	6
Antrim & Newtownabbey Borough Council	5
Lisburn & Castlereagh City Council	5
Derry City & Strabane District Council	2
Fermanagh & Omagh District Council	2
Total	**70**

Housing

8% of complaints related to housing.



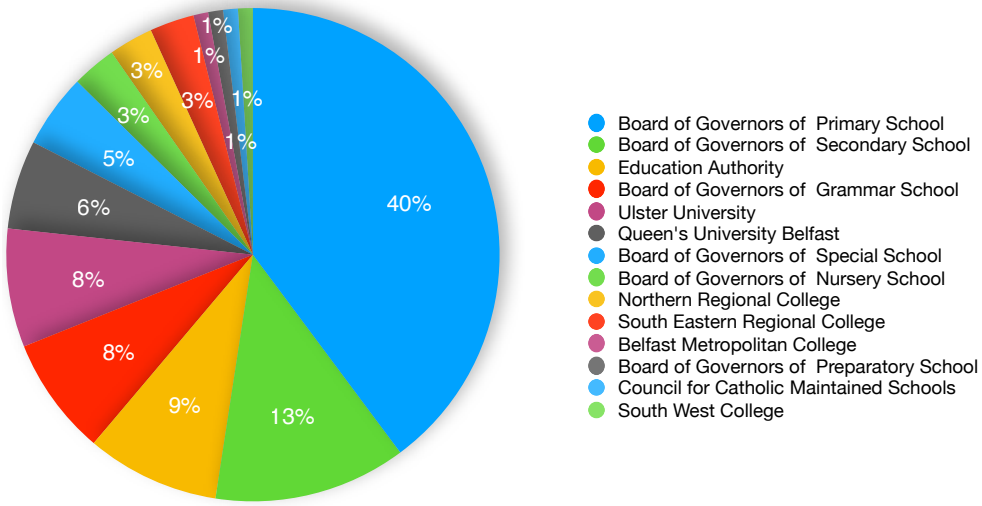
Examples of complaints about the Housing sector include issues with property management and repairs, the handling of requests for transfers and waiting list issues, and responses to allegations of anti-social behaviour.

Total Complaints about Housing

Housing Authority	Number of Complaints
Northern Ireland Housing Executive	43
Choice Housing	3
Radius Housing	3
Clanmil Housing Association Ltd	1
Fold Housing Association	1
Rural Housing Association Ltd	1
Total	**52**

Education

15% of complaints related to Education.



The Ombudsman's remit was extended at the beginning of the reporting year to include complaints about Boards of Governors of all publicly funded schools. The nursery, primary, secondary and tertiary education sectors are now all in jurisdiction, with complaints on issues such as Special Educational Needs cases, the handling of allegations of bullying and the provision of child protection and support services.

Total Complaints about Education

Establishment	Number of Complaints
Board of Governors of Primary School	41
Board of Governors of Secondary School	13
Education Authority	9
Board of Governors of Grammar School	8
Ulster University	8
Queen's University Belfast	6
Board of Governors of Special School	5
Board of Governors of Nursery School	3
Northern Regional College	3
South Eastern Regional College	3
Belfast Metropolitan College	1
Board of Governors of Preparatory School	1
Council for Catholic Maintained Schools	1
South West College	1
Total	**103**

Section Three
Ombudsman's Investigation Team

The Ombudsman takes a proportionate approach to investigations and seeks to make decisions on complaints as early in the process as possible. As outlined earlier, decisions on the majority of complaints are issued by the ASSIST Team. Only the most difficult and intractable cases pass to the Investigation Team for more detailed investigation..

Cases investigated

During 2017-18, **81** cases were passed to the Investigation team for more detailed investigation. This accounts for 12% of all complaints received during the year. The number of cases passed to the Investigation Team represents a 19% increase from the previous year and is broadly consistent with the overall increase in the number of complaints to the Ombudsman of 23%

In keeping with previous years a large percentage (76%) of the investigations relate to complaints about health and social care. There are a number of reasons why health and social care complaints account for such a high proportion of the investigation team's workload;

(1) The Ombudsman is able to examine the merits of a decision taken by health and social care professionals, as well as investigating allegations of maladministration. .

(2) To enable the Ombudsman to consider the range of issues in health and social care she has access to a range of specialist advisors who provide advice to assist with her consideration of the issues raised in the complaint. All cases where the assessment concludes that independent professional advice is required will pass to the Investigation Team.

(3) The issues raised in health and social care complaints often have a very significant impact on either those bringing the complaint or their family members.

During the year the Investigation Team completed **67** investigations, a 24% increase on the number completed in 2016-17. As well as increasing the number of investigations completed the Investigation Team also improved its performance against the targets of completing investigations to draft report stage within 50 weeks.

This improvement was achieved against a background of high staff turnover and the need to train and develop new staff into the procedures and processes followed by the Office.

The Ombudsman reported on 130 issues of complaint. Within a complaint it is often found that there is more than one discrete issue of complaint to be investigated separately. Hence the number of issues of complaints will exceed the number of recorded complaints.

Of the 130, 94 **(72%)** were upheld or partially upheld. A total of 36 **(28%**) of issues were not upheld.

The Investigation Team has continued to develop and refine its procedures to ensure that an impartial, fair, yet robust investigation is completed. Increasingly, to enable facts to be established at an earlier stage of the investigation, interviews with those involved in the complaint will be conducted. This approach has enabled the Ombudsman to focus her investigations on the key areas of disagreement, and is in line with her approach to greater proportionality in investigations.

Reporting on investigations

At the close of an investigation the provisional findings are shared with both the complainant and the public service provider. This approach enables both parties to raise any issues or areas of disagreement with the Ombudsman, and for her to consider these issues in detail prior to making her final decision on a complaint.

The issues raised at this stage may be noted in the final report.

Legislation governing the work of the Ombudsman states that every investigation must be conducted in private, and that information obtained by the Ombudsman relating to an investigation shall not be disclosed except in a limited number of circumstances.

The Ombudsman is therefore under a statutory obligation to protect the privacy and confidentiality of all information obtained for the purposes of her investigations and reports.

However, the Ombudsman is also committed to providing clear and transparent information about how the Office works in order to help members of the public or others who wish to complain about public services.

The Ombudsman believes in publishing reports on her investigations when it is in the public interest. The approach which has been adopted is set out in a Transparency Statement which was published during the year. The identities of complainants and other individuals will generally not be disclosed in these public reports.

The first public interest report, published in February 2018 concerned the former Department of Environment and found maladministration in the way it monitored an agreement on late flights with George Best Belfast City Airport.

Three other investigations, all concerning health issues, were published in the year.

Recommendations

The Ombudsman is keen to ensure that there are improvements in public services as a result of her investigations. Therefore in addition to publishing investigation reports and bulletins on case work to ensure the dissemination of learning, the Investigation Team follow up with the public service provider involved, seeking evidence that the recommendations made have been appropriately implemented.

The Ombudsman can ask the public service provider to:

- Issue an apology to the complainant
- Review their policies and guidance
- Share the lessons learned from the complaint
- Offer a financial remedy where the complainant suffered a monetary loss or significant injustice as a result of maladministration

The most common recommendations made in 2017-18 were for service improvement, or an apology to the complainant.

The case summaries on the following pages cover issues such as the care and treatment of patients in hospitals and nursing homes, the procurement process within a local council, funding for care home places in Northern Ireland, the monitoring of a planning agreement by a government department, and a school inspection.

Together they demonstrate the varied subject matter of investigations carried out by the Office.

Investigation Case Summaries

Complaint about patient's care and treatment by Royal Victoria Hospital staff not upheld

A woman complained about the care and treatment her elderly mother received at the Royal Victoria Hospital, Belfast. Having exhausted the hospital's complaints procedure she complained to the Ombudsman.

The complainant alleged that hospital staff had refused to allow her to be involved with her mother's care. She stated that she had cared for her mother at home for over 20 years and had wanted to assist in her mother's clinical care in hospital. This would help hospital staff to remove mucous from her lungs and attend to her pressure sores.

The Trust clarified that it was the policy of this hospital for suctioning to be carried out on inpatients by trained persons only, and that it would be normal practice to ask patients relatives to wait outside while it is performed. However, the hospital had established that the complainant was competent in dressing her mother's pressure sores and nursing staff were happy to allow her to take on this responsibility with support and supervision.

A report from an independent medical advisor stated that the care and treatment provided by the hospital was in line with good medical practice.

After consideration of all of the evidence the Ombudsman concluded that Royal Victoria Hospital staff had acted appropriately and reasonably in difficult circumstances.

The complaint was not upheld.

Council's process for tender of legal services 'characterised by avoidable delay, inaction and miscommunication'

In July 2009 a solicitor contacted the former Newry and Mourne District Council to ask whether there were any opportunities to tender for any legal service work. She was informed by the Council that the tender would be considered at a forthcoming Committee meeting and, if approved, would then be publicly advertised in the local press.

However in October 2009 she was informed that because of an impending merger of local Councils they had decided to postpone tendering for legal services.

She asked again in July 2010 and was informed that the Council intended to tender elements of its legal services at the end of January 2011.

When she asked in January 2011, the complainant was informed that the tender would be advertised before 31 August 2011. When that undertaking was not met, she made a formal complaint to the Council. In response, she was informed that the Council had entered into discussion with another Council in order to consider a joint tendering exercise and it intended to advertise for the tender in the very near future. The complainant was subsequently informed by the Council that its target date for publication was early January 2012.

When the tender was advertised the complainant sent in a pre-qualification questionnaire on 10 February 2012. However, having received no response, she wrote to the Council on five separate occasions throughout 2012.

On 11 January 2013, the Council wrote to the complainant to say it was not proceeding with the intended procurement exercise and that it intended to start a new process.

The complainant told the Ombudsman that participation in the procurement process had involved considerable time and resource on her part and that she was disappointed by the Council's decision. She stated that she had no confidence in the Council's stated intention.

The Ombudsman found multiple instances of maladministration by the Council in its handling of the procurement process. She concluded that 'the process was characterised by avoidable delay, inaction and miscommunication' on the part of the former Council.

The maladministration included the Council's failures to:

- keep to the commitments it provided to the complainant
- keep proper and appropriate records
- respond, on a number of occasions, to correspondence that it received from the complainant
- offer an apology and explanation, when appropriate, to the complainant in the course of her protracted correspondence with it in this case
- properly deal with the complaints made to it by the complainant

The Ombudsman recommended that the Chief Executive of the Council provide a sincere and comprehensive written apology to the complainant. She also recommended that the Council make a consolatory payment of £3,000 to the complainant.

The Council accepted the recommendations.

Investigation finds failings by Victims and Survivors Service

A complainant alleged that the Victims and Survivors Services (VSS) had unfairly placed him on its Unacceptable Client Register. He stated that the alleged incidents for which he was barred from the premises did not justify such action, in particular the claim that he was drunk on its premises during a visit.

The VSS responded to the Ombudsman's investigation enquiries by stating that the decision to designate the man as an unacceptable client was appropriate. It stated that he had a cumulative record of abusive and threatening behaviour and had the potential to cause distress to both VSS staff and vulnerable victims and survivors in its reception area. Further it stated that the decision to place him on the Unacceptable Client Register was taken in the interests of protecting the welfare of staff and others.

The man complained to the Ombudsman that he was not in the VSS premises on the day he had been accused of being drunk, and that he had asked VSS for the CCTV footage of the alleged incident. Seven months after this request he stated that the organisation informed him that the footage had been deleted after seven calendar days.

The man also informed the Ombudsman that because of a serious injury to his tongue his speech sometimes sounded slurred, and that he was aggrieved by people's presumptions that this was caused by drink.

The Ombudsman was critical of what she saw as the lack of sensitivity in the treatment of the man by the VSS, and concluded that the evidence to support the assertion that he was drunk on the premises on the day in question was not sufficient to have allowed them to treat this as an unacceptable incident.

She also expressed concern that the CCTV footage was deleted so quickly given the nature of previous incidents involving the complainant and the implications for him and the VSS staff. As a result he was deprived of the opportunity to view and respond to the allegations against him.

The Ombudsman concluded that the above failures, as well as maladministration in relation to other areas of record keeping, meant that the complainant experienced the injustice of uncertainty, upset and inconvenience.

She recommended that the Chief Executive of the VSS provide an apology to the man and a payment of £750. The VSS accepted and complied with these recommendations.

Complaint highlights concerns over funding for care home places in Northern Ireland

The daughter of a nursing home resident made repeated attempts over a five year period to clarify with the Southern Health and Social Care Trust whether her mother would be eligible for funded Continuing Health Care (CHC). Under the CHC system, an assessment of the individual is made to identify whether there is either a primary need for continuing healthcare which is provided free of charge, or a primary need for personal social services, which is means-tested.

The daughter claimed that the Trust gave her a number of conflicting answers to her questions, including that there was 'no such thing as Continuing Care'. Feeling that the Trust were continuing to evade her questions and aggrieved that they had refused to assess her mother, she made a complaint to the Ombudsman.

As part of the investigation the Trust confirmed that at the time of the request they used Departmental guidance issued in 2010 to help them assess individuals. They also confirmed that they had no internal policies and procedures regarding CHC, neither did the Trust have an internal definition of the term. There was also no review procedure of CHC decisions made by the Trust.

After examining the evidence the Ombudsman concluded that the Trust had failed to set up the necessary processes to give effect to the Departmental policy. As a result of this it was unable to assess applications in a consistent manner, and unable to provide applicants with adequate reasons for its decisions.

In the absence of the correct procedures the Ombudsman concluded that the Trust did not properly address the complainant's request for funding, and upheld this part of the complaint.

The investigation then also examined the resident's eligibility for funded CHC. An independent professional advisor advised that the resident's needs were primarily for personal social services. The Ombudsman therefore concluded that while the Trust failed to adequately assess the resident's CHC needs, there was no eligibility for funded CHC. This aspect of the complaint was therefore not upheld.

The Trust accepted the Ombudsman's report and provided an apology to the complainant.

The Ombudsman noted that this complaint highlighted a systemic issue which applies to nursing home residents in similar circumstances across Northern Ireland. In addition to recommending that the Trust establish new procedures for dealing with CHC requests, the Ombudsman also recognised that there were wider issues of concern in this area which needed to be determined on a Northern Ireland wide basis.

Ombudsman critical of Somerton Nursing Home's delay in calling for an ambulance

An investigation was carried out into the care and treatment provided to a complainant's late father, who had been a resident in Somerton Nursing Home, Belfast.

The resident was 82 at the time of the complaint. He had a history of numerous recurrent falls, vascular dementia, a previous stroke and heart disease.

He sustained a bump to the left hand side of his forehead following a fall at the home at 3.35am. The night nurse on duty contacted the out of hours doctor who advised that he be monitored. He stayed in the nursing home day room where he was observed and remained there until he went to bed at 5.00am.

The following morning, nursing home staff were concerned regarding the resident's condition and noted the bump had increased in size. Staff contacted the out of hours doctor again, who requested that an ambulance be called. A non-emergency ambulance arrived at 1.00pm to take him to hospital.

The resident was admitted through A&E and had a CT scan. This revealed a 'tiny amount of traumatic subarachnoid haemorrhage'. However 24 hour neurological observations were normal. He was discharged to a new nursing home in December 2014 but was admitted to hospital with abdominal pain and pneumonia later in the month. Sadly his condition deteriorated and he died in January 2015.

The home stated that staff had contacted the out of hours' doctor following the fall and the advice received had been not to call an ambulance.

The Ombudsman consulted a nurse independent professional advisor, who advised that the home's initial assessment and recording of vital signs immediately after the fall was appropriate. However, the advisor considered that given the circumstances, it was unacceptable that further observations were not recorded for 4 hours. From the description of a swelling on the head which gradually increased in size, the advisor considered a risk of more serious injury should have been suspected and an ongoing assessment needed.

The advisor stated that a nurse is not bound to follow the advice of the out of hours doctor if their assessment of the situation is that a 999 call is required.

Taking all of the evidence into account, the Ombudsman concluded that there was a failure by the home to document their observations of the resident following his fall, and that the delay in calling an ambulance represented a significant failure in its care and treatment of the man.

However, the Ombudsman also accepted advice received from a neurosurgeon IPA that there was no indication in the medical records that the resident's death was in any way related to or connected to his fall in the home.

The Ombudsman recommended that the home provided the complainant with an apology for the injustice of distress and uncertainty regarding the consequences to her father of the care and treatment which he received at the time of his fall. The nursing home agreed to do so.

Patient was given appropriate care and treatment by the Southern Trust prior to her death

An investigation by the Ombudsman found that the Southern Health and Social Care Trust provided appropriate care and treatment to a patient prior to her death from a serious heart condition.

The investigation began after a complaint about the care and treatment the man's late wife received from the Trust prior to her death.

The patient was diagnosed with a high grade Non-Hodgkin's Lymphoma. She was successfully treated with chemotherapy and entered remission. She was admitted to Daisy Hill Hospital, Newry with respiratory failure, during which time the complainant stated that his wife had been told by a doctor that her heart had been damaged as a result of an infection from a catheter used in her treatment four years earlier.

The complainant stated that the Trust failed his late wife as she was not made aware of the serious heart condition and that no after care was provided to her.

In responding to the complaint the Trust stated that the patient had been diagnosed with a heart infection but that this had been treated successfully with two courses of antibiotics. It stated that when the complainant raised the case with them, a Consultant Cardiologist reviewed the patient's records. He confirmed that the treatment was appropriate and that the infection had been 'cured completely'. The Trust stated that the poorly functioning heart problems were related to other causes.

After looking at the patient's medical records the Ombudsman's investigation could find no mention of the conversation recalled by the complainant. Although accepting this does not mean that the conversation did not take place, the Ombudsman was satisfied that after further examination of the patient's records and receipt of advice from the IPA, the previous infection suffered by the patient was resolved.

The Ombudsman was also satisfied that the patient did not suffer any long term consequences from this condition and that the final heart problem which she experienced prior to her death came from a different source.

The investigation concluded that there was no failure in the care and treatment provided by the Trust.

Former Department of Environment failed to monitor Planning Agreement with George Best Belfast City Airport

A complaint was brought to the Ombudsman on behalf of the group Belfast City Airport Watch Limited, which claimed that no action was being taken by the Department of Environment in relation to flight arrivals and departures at George Best Belfast City Airport between 9.30pm and midnight. The group claimed that the operation of flights during these times created unreasonable noise disturbance for those living near the Airport.

An Agreement between the former Department and the Airport allowed the flights only in 'exceptional' circumstances.

However, an Ombudsman investigation found that the Department had no operational definition of the phrase. In response to the Ombudsman's enquiries the Department stated that all of the 3000 plus late flights which took place over a seven year period were 'exceptional.'

The investigation also found that there were no written policies, procedures or internal staff guidelines on how any data gathered on delayed flights should be analysed. Further, there were no records that the information provided by the Airport to the Department was assessed in any way.

Issuing a finding of maladministration, the Ombudsman said; "In the absence of a definition of 'exceptional circumstances', and an established framework and procedures on how to analyse the delayed flights data … I conclude that the Department did not adequately meet its responsibilities in monitoring the 2008 Planning Agreement."

She recommended that the Department discuss with the Airport how to resolve the issues identified in her report. The Department accepted the Ombudsman's recommendations.

Ombudsman finds lack of patient consent before surgery a 'human rights issue'

The parents of a man who died in Craigavon Area Hospital shortly after ear surgery made a complaint to the Ombudsman. They had previously raised their concerns with the Southern Health and Social Care Trust but remained unhappy with the Trust's response.

Their complaint related to the care and treatment of their late son while in the hospital, and specifically their concern that his surgery may have contributed to his sudden death. They further complained that the Trust's investigation into what happened failed to appropriately follow policy and procedure and that the questions they raised remain unanswered.

The Ombudsman's investigation examined a number of issues, including whether appropriate consent was obtained from the young man prior to his surgery. The Ombudsman also looked at how the Trust handled its Serious Adverse Incident investigation.

Evidence gathered during the investigation included correspondence from the complainants, the Trust's complaint file, the patient's medical notes and the Serious Adverse Incident report. The Ombudsman also obtained specialist professional advice from independent advisors from the Royal College of Ear Nose and Throat.

The investigation established that the patient was admitted to the hospital for a routine ear operation. During the operation, an ossiculoplasty (a procedure to improve his hearing) was also carried out by the surgeon and he was fitted with a titanium prosthesis.

A few days after he was discharged he attended the out-of-hours GP complaining of chest pain. He was sent to Craigavon Area Hospital where he was diagnosed with a rare form of myocarditis (an inflammation of the heart wall). His condition deteriorated rapidly, and he sadly passed away shortly afterwards.

Based on the available evidence and independent advice, the Ombudsman concluded that the rarity and unpredictability of the patient's condition, and the rapidness of his deterioration, meant that his death could not be attributed to any failings on the part of the doctors who treated him.

The Ombudsman also found that the Serious Adverse Incident team completed a detailed investigation into his care and treatment.

(Continued over)

However, there were a number of areas in which failures in his care and treatment were identified. The most notable was over the issue of whether the patient gave his consent for the ossiculoplasty procedure.

The Trust stated that although specific consent was not requested or given, the procedure is considered 'part and parcel' of mastoid surgery. However, a submission by the professional body Ear Nose and Throat UK highlighted that there is 'mixed opinion' amongst surgeons in regard to the consent issue.

As the investigation was unable to find evidence that ossiculoplasty or the use of implants was discussed with the patient prior to his surgery, the Ombudsman concluded that there was a failure to meet the standards issued by the General Medical Council on the issue of consent and keeping accurate records.

The Ombudsman also drew attention to the human rights element of this case, in particular that the failure to provide the patient with all information relevant to ossiculoplasty, including the possible use of a titanium implant, did not meet the important human rights principle of participation by a person in decisions affecting them.

Further, the Trust were found not to have promptly and appropriately provided answers to the parents during the Trust's complaint process. These failures compounded their distress, as well as contributing to their mistrust and suspicion over what happened.

The Ombudsman acknowledged that the Trust have taken steps to learn from and remedy the issues she had identified. However she recommended that in future the Trust's Ear Nose and Throat surgeons should fully document for mastoid surgery where ossiculoplasty is likely. The Trust should also consider the production of an explanatory leaflet for patients on the procedure.

The Trust accepted all of the Ombudsman's recommendations.

Belfast Health and Social Care Trust did not fail in care of patient

A patient who attended a dermatology consultation in a hospital outpatient clinic complained about the doctor's behaviour during the consultation. He also believed that he was misdiagnosed and that the Trust did not properly deal with his complaint.

The Investigating Officer reviewed the hospital's medical notes and accounts provided by the doctor and two medical students who were in the room during the consultation. The Ombudsman also obtained independent professional advice in relation to the diagnosis.

Having considered all the available evidence the Ombudsman found that the care and treatment provided by the doctor was reasonable.

However, during her investigation into the complaint handling issue, she found that the Trust had accused the patient of using offensive language in a telephone call to a member of staff in its complaint department. The patient denied this and asked the Trust to clarify what it meant.

The investigation found that although staff made a record of the phone call in question the record did not include details of the offensive language. This omission meant the Trust could not adequately respond to the patient when he challenged its allegations of misconduct.

The Ombudsman reminded the Trust that the maintenance of full and accurate records means that complaints can be investigated more thoroughly, and complainants less likely to claim they have suffered an injustice.

Her report therefore recommended that Trust staff should make full and contemporaneous records in instances where they feel they have been subject to inappropriate language, and for it to provide evidence that this change has been implemented.

Recommendations made following school visit by Education and Training Inspectorate

The Board of Governors of a Primary School complained about a number of issues relating to the inspection conducted at the school by the Education and Training Inspectorate (ETI).

The Governors believed that during the inspection there was overly negative feedback from the inspection team, and that this impacted on teaching performances during the inspection.

They also complained about how the ETI subsequently investigated their complaint, and in particular what they said was an unsubstantiated claim made by the ETI that the school principal had breached a confidentiality agreement.

The Ombudsman found that without contemporaneous notes of the exchanges between the ETI and teaching staff she was unable to conclude whether the tone was overly negative.

However, while she was able to find that there was nothing wrong with some aspects of the inspection, she concluded that there was a failure to provide feedback in an appropriate setting to one teacher, and inappropriate questioning of another teacher which did not meet the standards of the ETI code of conduct.

In relation to the way in which the schools complaint was investigated, the Ombudsman found that the ETI did not act fairly regarding the comments made about a possible breach of confidentiality. She also found that the investigators accepted the evidence of inspectors over that of teaching staff regarding certain issues of the complaint. While acknowledging that the investigator's decision as to the weight of the evidence is a discretionary decision, the Ombudsman found the absence of any rationale for this decision to be a failing.

The Ombudsman made a number of recommendations to the ETI to improve service delivery, and recommended that it apologise to the school for the failings identified in the report, These recommendations were accepted.

Section Four
Performance Analysis

How we measure performance

Delivering operational efficiency, effectiveness and accountability is a priority for the Ombudsman. This is measured through key performance indicators (KPIs). The indicators focus on the time taken to complete investigations. Complementary qualitative assessments are completed through established internal procedures including a robust Quality Assurance framework. The Office's maladministration complaints KPIs are as follows:

KPI 1 – measures how quickly we establish whether the complaint **can** be investigated by this Office. We aim to inform the complainant within **2 weeks** or less of their complaint being received. The target is 90%.

KPI 2 – measures how quickly we complete our assessment of whether a complaint **should** be investigated by this Office or is suitable for settlement. Assessment is a detailed process which involves considering the complaint and the supporting evidence from both the complainant and the body complained of. This represents case-building in the event a case proceeds to investigation. We aim to complete the assessment process and inform the complainant of the decision within **10 weeks** or less of their complaint being received. The target is **70%**.

KPI 3 – measures how quickly we complete the **investigation** of a complaint and issue a draft report to the body involved. We aim to complete this within **50 weeks** or less of the decision being made to investigate. The target is **70%**.

The achievement rates in respect of KPI 3 below distinguish between the more recent cases arising under NIPSO's legislation and cases brought forward from the previous Assembly Ombudsman/Commissioner for Complaints (AOCC) legislation – so-called legacy cases[1]

KPI	Target	Result for reporting period	Target Met/ Not met
1	90%	95%	Met
2	70%	62%	Not Met
3	NIPSO Cases	91%	Met
3	Legacy Cases	45%	Not met
3	Combined (70%)	75%	Met

1 For the early years of NIPSO the Office has separately tracked performance on cases that were brought forward under the previous Assembly Ombudsman/Commissioner for Complaints legislation ("legacy" cases). It is expected that this distinction shall be removed from 2018-19.

As the above table shows, achievement against the KPIs in 2017-18 was broadly positive, particularly regarding the more recent complaint cases arising under the NIPSO jurisdiction. NIPSO met two out of the three investigation targets. Within KPI 3 the legacy target was not met, but when combined with KPI 3 performance on NIPSO cases the overall target was exceeded (75%).

Where targets were not met this must be viewed in the context of the links between KPI performance and the significant risks and uncertainties to which NIPSO is exposed. The predominant risk factors that are of relevance to NIPSO's complaints case handling performance are:

(i) Increasing case numbers beyond the levels forecast (e.g. 23% growth in 2017-18);

(ii) Turnover and unavailability of short term staff; and

(iii) In the absence of the Assembly, uncertainty over future years' resources and inability to identify and mitigate future financial pressures.

Despite these significant risks KPI 1 was met in 95% of cases - ahead of the 90% target. The average number of days taken to reach the '***can*** we investigate' decision at this stage was 9.

The reported percentage performance for KPI 2 (assessment of whether a case ***should*** be investigated) was 62%. This fell short of the 70% target. However, the average number of days taken was 72: just above the 10 week target completion time. The main reason for the reduced KPI 2 performance was the surge in complaints activity and staffing shortages due to long term sickness.

Following on from the 'should we investigate' decision, the KPI 3 performance target was met in 91% of NIPSO cases. Whilst performance on legacy cases (45%) served to bring the overall KPI 3 performance down to 75% this is a very creditable result against the 70% target.

The Ombudsman continues to keep under review the key performance measures as the new NIPSO jurisdictions continue to expand with the extended remit for social care, schools, universities and further education colleges as well as judicial appointments.

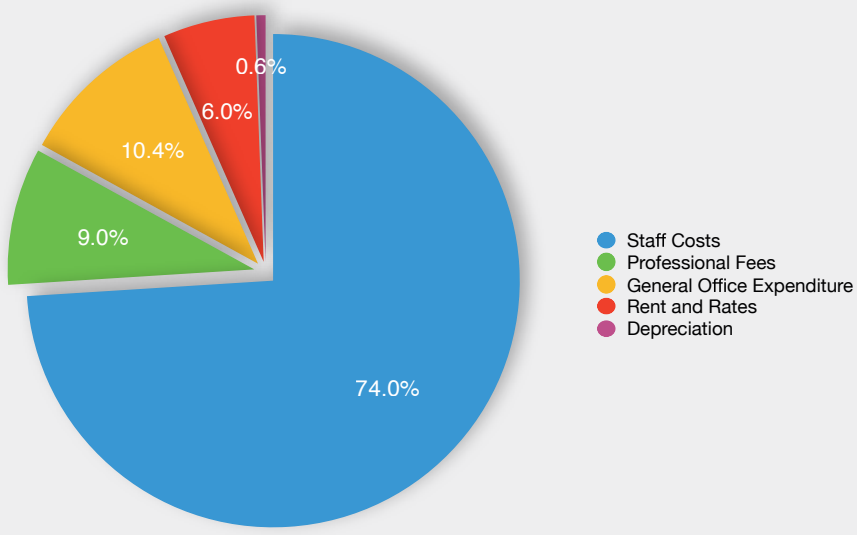
Financial performance

The Following summarises NIPSO's audited expenditure during 2017-18

(All £k)	Maladministration (incl NIJAO)	Local Gov't Ethical Standards (LGES)	Total
Staff Costs	1,441	217	1,658
Other Administration Costs	532	70	602
Total expenditure	**1,973**	**287**	**2,260**

In overall terms this represents a growth in expenditure of some 24% from the £1,816k incurred in 2016-17. All of this increased expenditure is attributable to increased Maladministration complaints activity. It is largely attributable to the growth in staff numbers required to meet NIPSO's rapidly expanding maladministration complaints case load and expansions in jurisdiction.

Illustrated below is the breakdown of NIPSO's resource expenditure for 2017-18.



Staffing

The breakdown of actual staff in post (headcount) at 31 March 2018 was as follows:

	Male	Female	Total
Ombudsman/Deputy Ombudsman	1	1	2
Other Senior Management Team	2	2	4
Other Staff	12	22	34
Total	15	25	40

The total of 40 represents an increase of 18% from the 34 in post a year earlier.

Absence Data

Sickness absence data for 2017-18 was as follows:

Working Days lost 2017-18	Average days lost per WTE member of staff	Absence Rate 2017-18 %
369	10.6	4.8%

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.

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