CASE Digest

Issue One
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Northern Ireland
Public Services
Ombudsman

Welcome to our Case Digest!

The Northern Ireland Public Services Ombudsman (NIPSO) looks at complaints from people who feel they have been treated unfairly by a provider of a public service.

Ombudsman is a Swedish word meaning a 'trusted official'. An Ombudsman acts as a neutral observer, aiming to find out if an organisation's actions have caused unfairness or harm, or if there is no basis to a complaint. It is often seen as providing an alternative to court.

My Office will generally only consider complaints after the public service provider has considered the issues of complaint through their formal complaints procedure.

If we decide to investigate a complaint we will ask the public body to send us all relevant details. We have the power to compel bodies to provide us with documents and to interview officials.

If we find that there has been maladministration (ie. failure to apply the rules properly, unreasonable delay, rudeness, bias, ineptitude, etc.) we may make recommendations to address it. Our recommendations look at providing a remedy for the complainant and what can be done by the body to prevent similar failures in the future.

This Case Digest provides summaries of a number of recent complaints we have dealt with. I hope it will be of interest to you.

Marie Anderson

Marie Anderson
Ombudsman

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

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

The complaint

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

The investigation

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

This advice stated that when the patient's condition was first spotted it was not given an appropriate assessment by medical staff. (cont'd)

Given the seriousness of some red-eye conditions the advisor stated that it potentially needed to be referred to the eye casualty department.

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

The outcome

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

She found:

- That there was a failure by the Northern Health and Social Care Trust to appropriately assess and seek timely expert advice regarding the patient's eye condition. This failure continued after the initial inadequate assessment as several other doctors and consultants examined or reviewed him.
- That the system in place at the Belfast Health and Social Care Trust for handover, referral, prioritization, and monitoring of patients did not ensure that he was reviewed as a priority.
- That an earlier diagnosis would have ensured that antibiotics were given at the appropriate time and this would have much improved the chances of the patient retaining his vision.

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

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

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 Automotive 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.

Complaint about GP not upheld

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

The complaint

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

The investigation

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

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

The outcome

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

The complaint was not upheld.

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.

Hospital conditions not the cause of patient's pneumonia

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

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

The complaint

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

The investigation

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

The outcome

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

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

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

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

This part of the complaint was not upheld.

Council dealt appropriately with planning application - Ombudsman

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

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

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

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

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

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

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

The complaint

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.

The investigation

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 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.

The outcome

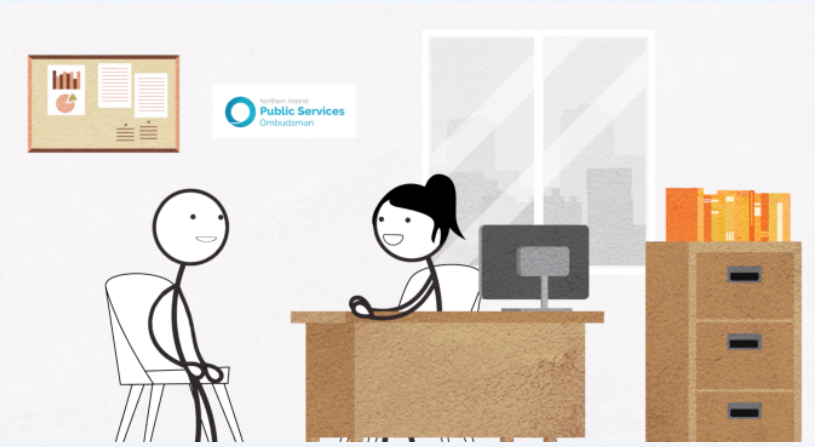
Issuing a finding of maladministration, the Ombudsman said; "In the absence of a definition of 'exceptional circumstances' and an established framework and procedures on how to analyse the delayed flights data … I conclude that the Department did not adequately meet its responsibilities in monitoring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

NIPSO - A short video guide

We have produced a short animated video for members of the public. It explains in simple terms when they can complain about a public service and how the Ombudsman may be able to help. Visit our website and click on the video to view.

www.nipso.org.uk



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

The complaint

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

The investigation

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

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

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

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

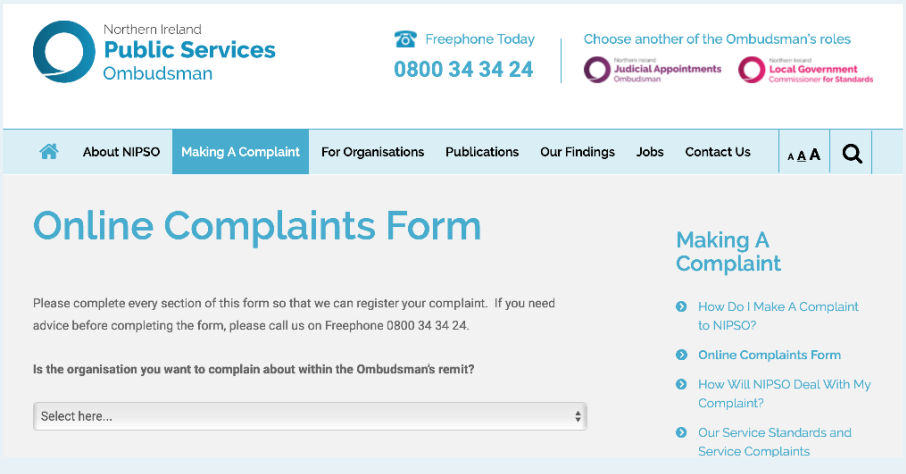
In relation to the concerns about the resident's weight loss, the findings of the Trust's investigation and the professional advisor's comments were both considered. These stated that the total weight loss was less than that which warranted a referral to a dietician. This part of the complaint was not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

The outcome

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

How to make a complaint to the Public Services Ombudsman

The quickest way for your complaint to be registered with us is by completing our online complaints form. However, you may also contact us by phone, email or in writing.



Northern Ireland Housing Executive made 'fair and reasonable efforts' to address concerns

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

The complaint

At meetings with the NIHE the man made numerous complaints concerning noise nuisance coming from the neighbouring property. By way of resolution he stated that he wanted either the tenant evicted or the NIHE to buy or rent his property, thereby allowing him to relocate. After being told that this was not possible, the man complained to the Ombudsman.

The investigation

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

The investigation obtained all relevant documentation relating to the complaint.

The investigation revealed that in this case the NIHE properly followed its anti-social behaviour policy. It liaised extensively with the relevant bodies such as the PSNI and obtained legal advice. It also

interviewed both the man and his neighbour on more than one occasion, arranged mediation between the two parties and met with the man's political representatives.

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

The outcome

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

The complaint was not upheld.

Patient was discharged prematurely from hospital's Emergency Department – Ombudsman

The complaint

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

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

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

The investigation

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

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

The outcome

However, the Ombudsman found that after receiving treatment the patient should have been moved to an observation ward and not the waiting room. She also found that observations should have been carried out by Trust staff and her discharge delayed until she was considered well enough to tolerate fluids and food. The Ombudsman recommended that the Trust apologise to the patient for the injustice suffered.

Ombudsman upholds complaint that hospital failed to arrange care package for patient

A hospital Trust has apologized to a patient who was forced to arrange her own care package after being discharged from hospital.

The complaint

The patient had surgery for a fractured arm following a fall at home. She complained to the Ombudsman that before discharging her staff in the Royal Victoria Hospital, Belfast should have provided her with an Occupational Therapy or Social Work assessment. She stated that because of their failure, she was left to care for herself over the weekend before independently arranging a package three days after leaving hospital.

The investigation

The Ombudsman's investigation looked at guidance from the Department for Health on discharge planning, the Trust's own discharge principles and other relevant professional guidance. It also looked at the patient's medical records and took advice from independent medical advisors.

The patient stated that she had explained to physiotherapy and nursing staff that given her age (67), complex health conditions and the fact that she lived alone at home in a two-storey house, she would have difficulty coping. She further explained that her next of kin was her 72 year old cousin who also suffered from various health conditions.

Independent professional advice provided to the Ombudsman stated that there was no evidence that the patient was involved in the discharge process. This was contrary to the guidance which states that there should be an 'effective person-centred' and 'fully integrated approach' to discharge planning.

According to the advisor, the patient should have been given an assessment from the Occupational Therapist or Social Worker before being allowed home.

In response, the Trust said that if patients raise concerns prior to discharge, the ward nursing team should refer the patient to the relevant service. However, unfortunately in this case this was not done. The Trust stated that it was extremely sorry that the patient's concerns were not followed up.

The outcome

After examining the evidence the Ombudsman concluded that there was a collective failure by the hospital's Multi-Disciplinary Team to appropriately follow up on the patient's concerns about coping at home. As a result she was not given the proper care she needed on leaving the hospital. The complaint was therefore upheld.

Following the recommendations made in the report the Trust apologized to the patient for the errors made in this case, and made a payment to her in acknowledgement of the upset and distress caused.

Northern Ireland Public Services Ombudsman

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Opening Hours:
9.00am - 5.00pm, Monday to Friday