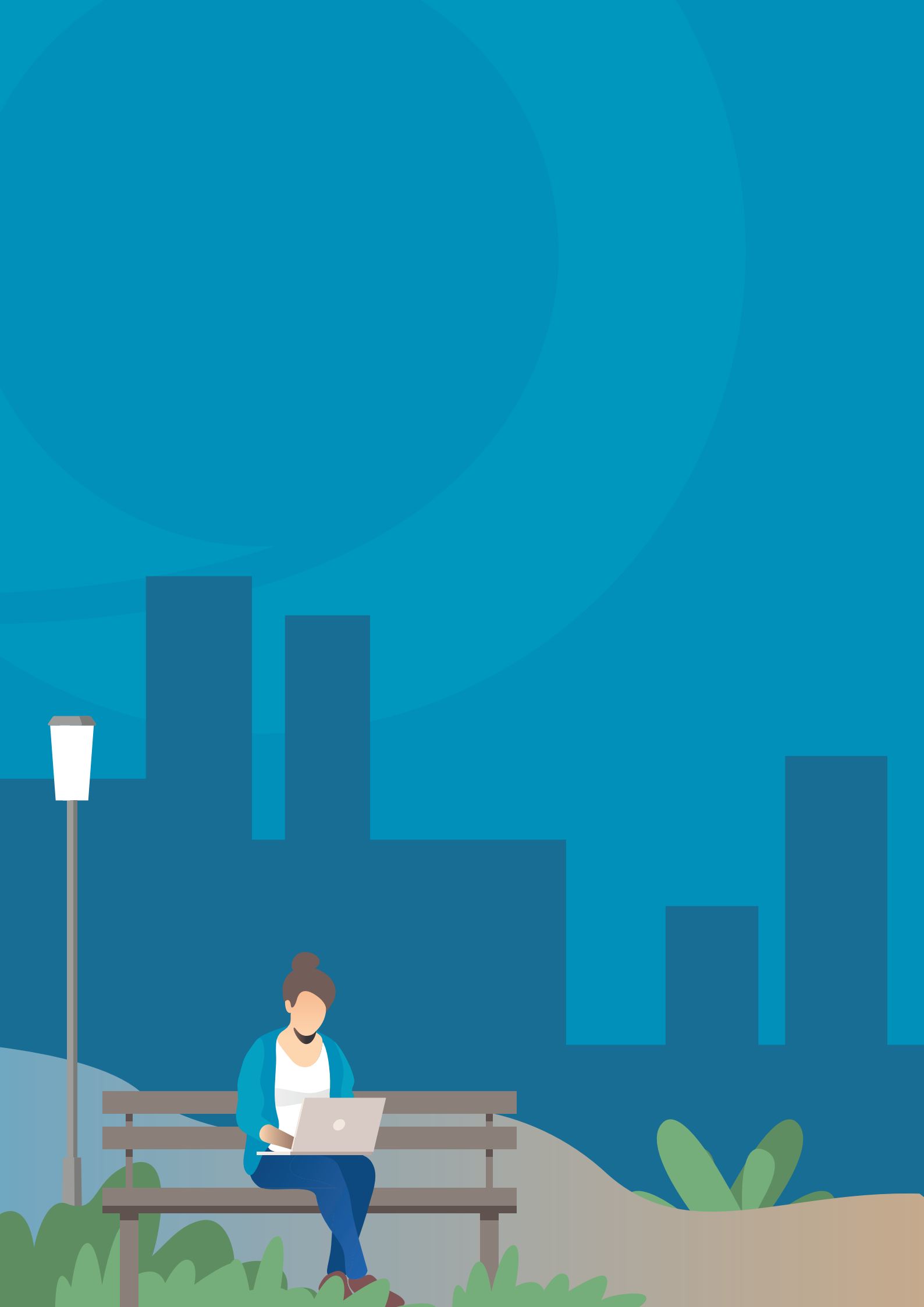
NIPSO

Ombudsman's Report

2024-25

Northern Ireland
Public Services
Ombudsman



Contents

Foreword
from the Ombudsman

I am pleased to introduce my Ombuds report for the year 2024/2025, during which time there has been an increase in both the number of complaints to the Office and in their seriousness and complexity.

During the year we received 1333 complaints to the Office which is an increase of 14% on the previous year and we also recorded an additional 2002 enquiries. The trend of increasing numbers of complaints coming to the Office is one that we have seen consistently since the inception of NIPSO in 2016.

14%

increase in number of complaints during 2024/25

The Ombudsman has a unique role in the administrative justice landscape in promoting accountability and transparency and in ensuring all citizens are treated equitably and fairly by public services. It is vital that citizens know how and when to access the Office and that our service is free, independent and impartial. Many people who bring complaints to the Office want to ensure that their experience does not happen to anyone else and it is important that citizens realise that in bringing complaints they can aid the improvement of public services generally.

Further, bringing complaints may also improve trust in public services by demonstrating not only that public services may be questioned by the citizen and that there is a route to redress, but that doing so results in improvement and sometimes in systemic change. The right to complain is always important but particularly so when there are unprecedented pressures on public services.

This report focuses on a number of key areas and themes, including the work of the Office on patient safety in health and social care, the increase in housing complaints against a backdrop of increasing homelessness, and developments in addressing statutory complaints standards.

There are three further themes - access to justice and the accessibility of the office, the importance of good communication, and compliance and learning from complaints.

I hope it illustrates the breadth of the work of the office and the difference it can make for both individuals and public bodies, as well as its importance in ensuring access to justice for all citizens who may need it.

Margaret Kelly

Northern Ireland Public Services Ombudsman

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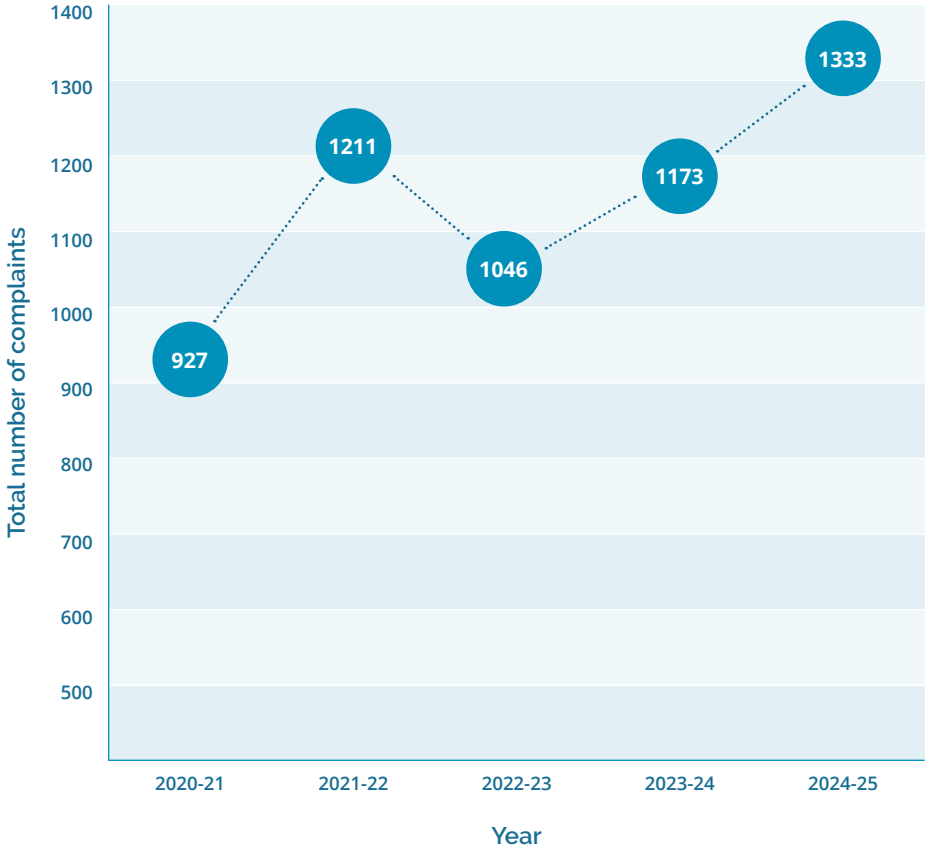
The Year in Numbers

The Year in Numbers

Complaint Performance Statistics



1333
complaints this year

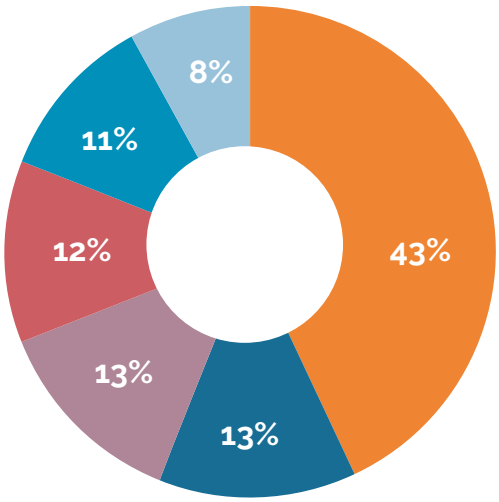
14%
increase from 2023/24

44%
increase since 2020/21

2002
Total enquiries

Breakdown of Complaints

- Health & Social Care
- Central Government
- Housing
- Education
- Local Government
- Other



102
investigation reports issued

84%
of cases at Further Investigation were in the health and social care sector.

Delivery and Performance

KPI 1

We aim to inform the complainant within 10 working days of receiving their complaint whether we can accept it for investigation.

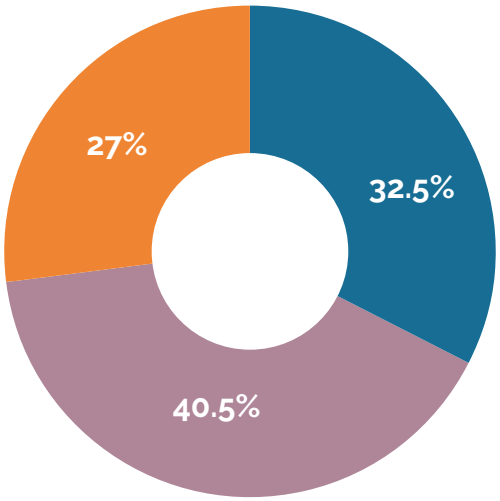
KPI 2

We aim to inform the complainant within 50 working days of receiving their complaint whether it can be resolved, closed or progressed to further investigation.

KPI 3

We aim to issue a draft report for consideration within 50 weeks of the decision to further investigate.

Impact



- Fully upheld
- Partially upheld
- Not upheld

73%
were either fully or partially upheld

217
recommendations made to improve public services and provide redress to indivduals

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Our Investigations

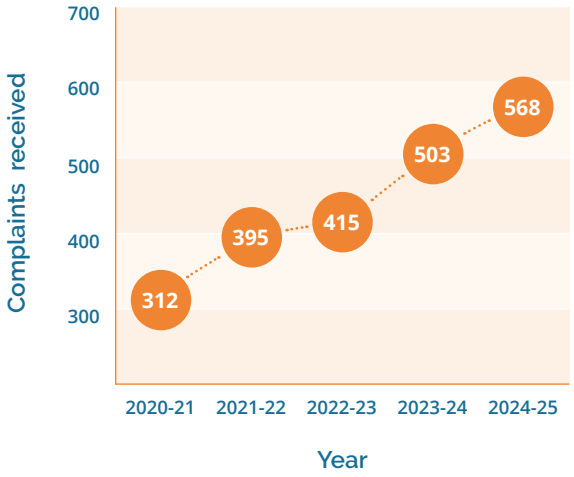
Highlighting opportunities for improvement and increased trust in public services through the investigation of complaints

Health and Social Care

"In the last 18 months I have certainly seen more cases of serious harm or death in healthcare settings, and that is a cause for concern."

Margaret Kelly

Northern Ireland Public Services Ombudsman



We are all acutely aware of the pressure that our health and social care system continues to face, and despite reviews and recommendations our health service has continued to operate under unprecedented pressure. Nonetheless, when something goes wrong it is critical that the issue is properly investigated and those affected given an open, honest and detailed response. This is vital not just for individuals and their families but also for the maintenance of public trust.

We have seen an overall upwards trend in complaints to NIPSO, and health and social care complaints have always been the largest category of complaints that we receive. However, since 2020/21 overall complaints to NIPSO have increased by 44%, whereas those from health and social care have increased by over 80%. Further, the complaints have increased in both complexity and seriousness. This is why, as well as investigating and addressing complaints from individuals, we have also sought to continue to prioritise issues of patient safety as a major theme in health and social care complaints.

Breakdown of complaints received in 2024-25

Roughly three quarters of the complaints we received last year were about services provided by the Trusts.

Health Trust	2024-25
Belfast Trust	131
Northern Trust	84
South Eastern Trust	69
Western Trust	63
Southern Trust	62
South Eastern Trust (Prison healthcare)	7
Northern Ireland Ambulance Service Trust	6
Total	**422**

Others	2024-25
General Practitioners (GPs)	95
Dentists	18
Private nursing homes	14
Independent HSC providers	9
Business Services Organisation (BSO)	5
Northern Ireland Social Care Council	2
Out of hours GP services	1
Patient Client Council	1
Public Health Agency	1
Total	**146**

Patient Safety

Analysis of final investigation reports about health & social care complaints shows that in 2024/25 the Office issued 19 investigation reports into circumstances in which a patient died or significant harm was caused to a patient. This included the death of an unborn child whilst the mother was in hospital, the death of a complainant's mother after the failure to properly assess her injury and accurately read scan results, whilst a failure to identify and treat sepsis contributed to another death.

Not everyone admitted to hospital will recover and sometimes errors will happen. However, it is disappointing that relatives and loved ones who made a complaint, had to exhaust that process and then come to the Ombudsman to get the explanations and answers they needed. This undoubtedly compounded the suffering and loss they had experienced.

It is essential that health and social care providers embrace the recently launched Model Complaint Handling Procedure to be more open with patients, seek opportunities to resolve issues at the earliest possible point and conduct comprehensive investigations that fully answer complainant concerns.

'Fundamental failings' led to death of unborn baby

A woman who was 33 weeks pregnant was admitted to Craigavon Area Hospital with severe abdominal pains.

Our investigation found that had an emergency caesarean section been carried out it is likely her baby would have survived.

Extract from the report:
'I wish to comment on the SAI review panel's determination that the medical record was an 'error'. I am disappointed that the panel did not identify the seriousness of this falsification of a patient record. I would ask the Trust to share my concerns with the panel for future learning.'

Case Ref: 202004555

Trust's failures led to patient's untimely death

The Northern Trust failed to act on a woman's concerns about her mother's health. This, as well as its failure to properly assess her spinal injury and accurately read the results of an MRI scan, led to her untimely death.

Case Ref: 202002627

Care and treatment failures contributed to death of patient

Altnagelvin Hospital treated a man with severe abdominal pain. Our investigation found that a series of delays in his care and treatment, and a failure to manage his sepsis, contributed to his death.

Case Ref: 202001646

GP practice should have referred patient for further tests

A woman claimed that if her late husband's weight loss had been investigated properly his cancer may have been detected sooner.

We found it was a 'significant failure in care and treatment' that his GP didn't send him for further diagnostic treatment.

Case Ref: 202005762

Child unnecessarily restrained after Trust failed to monitor use of specialist seating

The Western Trust approved two special chairs for an autistic boy to use in school without properly assessing his needs. The Trust should also have given the school clearer instructions on how the chairs were to be used.

Extract from the report:
'It is evident from my reading of the records how involved the complainant was in her child's care and how she strived to speak for him when he was unable to do so himself. I hope this report goes some way to address the complainant's concerns about the care the child received.'

Case Ref: 202000387

Driving improvement through impact and compliance

As well as addressing individual complaints and ensuring that Trusts and health care services complied with our recommendations, we sought to share learning from our investigations and to contribute to improvement at a systemic level. In addition to complaints investigations, we also engaged with the Northern Ireland Assembly. This included:

- Oral evidence to the Committee for Health on patient safety and the duty of candour
- A consultation response to the Department of Health on Being Open
- A contribution to the Committee Inquiry into Palliative Care

We also published a Case Digest on complaint investigations in Care Homes where we shared lessons for improvement.

We monitor compliance with our recommendations to ensure that public bodies implement the recommendations to which they have agreed. The case study opposite illustrates a positive broader system change from an individual complaint.

Treatment of a patient in the South West Acute Hospital

A woman complained about the discharge of her husband from hospital, who was in pain and was feeling suicidal. The Trust was asked to improve care for patients with acute mental health needs and review its own investigation failings. In response to a review it undertook, the hospital introduced wrist bands at the point of registration for all non-minor injuries patients, ensuring better patient identification and safety during ED stays.

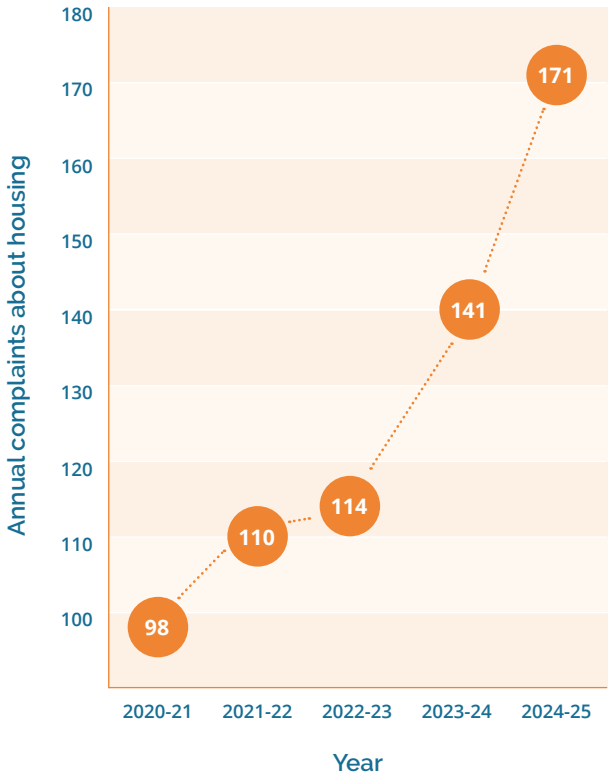
Case Ref: 202000376

Housing

Highlighting opportunities for improvement and increased trust in public services through the investigation of complaints

Access to good quality, secure social housing continues to be a significant challenge for too many in our society. Over the last decade we have seen the number of those registered as homeless rise exponentially. In June 2024 there were 58,000 homeless people in Northern Ireland. Both the number of those in temporary accommodation and the amount of public money spent has risen exponentially, with £39.9 million spent on temporary accommodation in 2024/25. This means maintaining the current housing stock is vital and a core element of the strategy to address housing needs.

Further responding openly and respectfully to complaints and using them as an opportunity to understand underlying trends and issues is a key element of continuous learning and improvement.



Complaints to NIPSO overall have increased by 44% but complaints in relation to housing have increased by 74% since 2020/21.

The importance of good quality housing to health and wellbeing cannot be underestimated, and when people complain it is essential that public bodies properly and appropriately record their complaints and use the data to understand trends and issues. This enables public bodies to have a focus on early resolution and improvement.

Concerns regarding the handling of complaints and complaints responsiveness, as well as the growing number of complaints, led the Ombudsman to write to the Northern Ireland Housing Executive, proposing to undertake an Own Initiative investigation[1]. At the time of the proposal we said: *'Access to high quality and safe housing is important in reducing health inequalities and improving the overall wellbeing of our population. A good maintenance and repairs service is one of the most important responsibilities landlords have. It is important there is confidence in how the Housing Executive delivers this service and responds when concerns are raised about housing conditions.'*

Breakdown of complaints received in 2024-25

Housing Association	Total
Northern Ireland Housing Executive	119
Radius	17
Choice	11
Clanmil	7
Others	17
Total	**171**

[1] In June 2025 the Ombudsman confirmed that an investigation had begun.

Report recommends review of how the Northern Ireland Housing Executive handles complaints

We upheld a man's complaint about the Housing Executive's failure to deal with his enquiries about emergency accommodation.

Extract from the report:
'When making enquiries of the NIHE, I noted its resistance to participate fully in my investigation. I should highlight that it is unusual for any listed authority in jurisdiction to fail to provide this office with documentation and information when requested to do so, particularly when such information requests are repeated. However, despite raising similar concerns with the NIHE in 2023, its continued resistance to engage with my office increases my concern.'

Case Ref: 202005280

Concerns about asbestos in tenant's property

A tenant complained that the Northern Ireland Housing Executive refused to discuss her concerns about asbestos in her property. She said she had made numerous attempts to find out what its policies and procedures were for managing asbestos, but said she was ignored.

Following our enquiries the Housing Executive agreed to meet with the tenant to discuss her concerns. It also said it would review its Asbestos Policy and the information it provides to other tenants about asbestos management.

Case Ref: 202004802

Housing Executive correctly assessed man's application.

A man claimed he was treated unfairly by the Housing Executive when it rejected his application for a three-bedroomed house. He said this was necessary for his young son and daughter to have separate rooms.

We recognised the difficult circumstances faced by the man, but were satisfied the Housing Executive correctly applied its guidance and rules when it considered his application.

Case Ref: 202004826

Local government

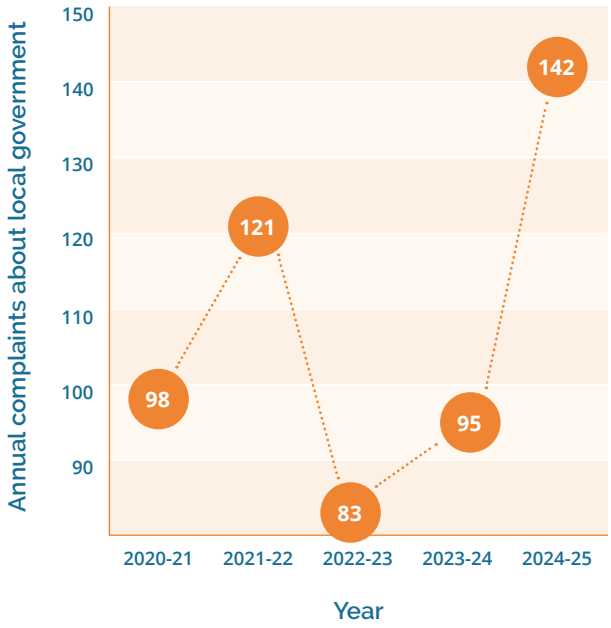
Highlighting opportunities for improvement and increased trust in public services through the investigation of complaints

44%

increase in number of complaints about local government services.

Complaints about local government services including environmental protection, waste management and planning have seen a significant increase during the year. However, since 2020/21 they have increased by 44%, which is similar to the overall rate of increase in complaints to NIPSO as a whole.

During the year the local government sector fully adopted the new complaints standards approach. This requires public bodies to record all complaints and provide a more simple, straightforward and complainant-focused response.



Breakdown of complaints received in 2024-25

Local Government Area	2024-25
Belfast City Council	26
Causeway Coast & Glens Borough Council	22
Ards & North Down Borough Council	15
Lisburn & Castlereagh City Council	15
Newry, Mourne & Down District Council	15
Antrim & Newtownabbey Borough Council	11
Derry City & Strabane District Council	11
Armagh City, Banbridge & Craigavon Borough Council	8
Mid & East Antrim Borough Council	7
Mid Ulster District Council	6
Fermanagh & Omagh District Council	4
Northern Ireland Local Government Officers' Superannuation Committee (NILGOSC)	2
Total	**142**

Complaint led to greater engagement between council and residents

A woman complained that Antrim and Newtownabbey Borough Council failed to ensure property developers complied with planning conditions when building on land near her house. She said her property was flooded as a result.

In bringing her complaint to us she sought compensation for the damage to her home, for the council to provide a representative to work with the local Residents Group, and for the council to ensure more governance of planning conditions.

As a result of our intervention the council proposed a meeting between Council Officers and around 30 members of the Residents Group.

Case Ref: 202006397

Council dealt with complaint in line with procedures

We investigated a complaint from a man who believed that Ards and North Down Borough Council should have independently verified whether planning orders had been breached, rather than taking the word of the developer. We did not uphold the complaint.

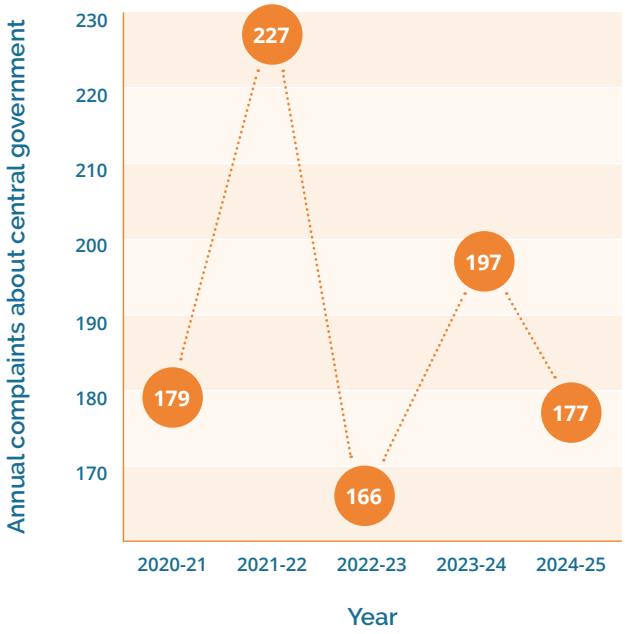
Case Ref: 202003408

Central government

Highlighting opportunities for improvement and increased trust in public services through the investigation of complaints.

We can investigate complaints about maladministration in all central government departments. However, these complaints have not seen the same rate of increase as some other areas of NIPSO's jurisdiction.

Some central government departments will have a greater degree of interaction with the public than others and ensuring that government departments have a simple, straightforward complaints process which is easily accessible is a key area of focus for NIPSO going forward.



Breakdown of complaints received in 2024-25

	2024-25
Department for Communities	67
Driver and Vehicle Agency	27
Department for Infrastructure	17
Department of Justice	12
Department of Finance	10
Department of Education	8
Land and Property Services (Department of Finance)	8
Courts and Tribunals Service (Department of Justice)	7
Department of Health	5
Department of Agriculture, Environment and Rural Affairs	4
Equality Commission	2
Northern Ireland Environment Agency	2
Victims and Survivors Service	2
Public Records Office NI (Department for Communities)	1
Belfast Harbour Commissioners	1
Appeals Service (Department of Justice)	1
Legal Services Agency (Department of Justice)	1
The Executive Office	1
Probation Board	1
Total	**177**

Investigation of a complaint about the Department for the Economy

We upheld a complaint from a man who claimed that failures by the Department for the Economy resulted in his partner sustaining a significant financial loss.

He claimed that the Department had failed to monitor the actions of an insolvency practitioner who was the supervisor of an individual voluntary arrangement which she had entered into 2006.

The man also said his partner was aggrieved that it took more than two and a half years to investigate the complaint and to notify her of the outcome.

Our investigation found that in most of its monitoring visits to the insolvency practitioner it did not review an appropriate sample of insolvency cases.

It also found that when concerns were raised about certain aspects of the insolvency practitioner's conduct, the Department did not ensure it was satisfied they remained a fit and proper person to hold a licence.

Significantly, we found that the staff members responsible for conducting the monitoring visits did not have the necessary skills to do the job, and because there was no one suitably trained to investigate the complaint the Department had to appoint an external investigator.

We also established that the Department failed to tell the complainant why its investigation was taking so long and did not provide her with a proper explanation of the findings when it was completed.

We asked the Department to apologise for the failings and recommended that it check whether its staff who have responsibility for the implementation of other regulatory functions within its remit have the appropriate training and skills to do the job effectively.

Case Ref: 202000405

LPS agrees consolatory payment to ratepayer

The Land and Property Services acknowledged an error in how it calculated a man's rates. It reduced the rateable value of his property by £65,000 and refunded him six years' worth of overpayments. However, the man said that he had been overpaying by a total of 13 years so believed he should get a refund for the full period he was overcharged.

After we contacted the LPS it agreed to make a consolatory payment of £2400 to the man, which covered the full amount of the overpayment, and provide him with an apology for the mistake.

Case Ref: 202005019

Properties receive broadband following man's complaint

A man complained that he hadn't been able to benefit from the rollout of a new superfast broadband scheme in his area because his address was not on a list used by the Department for the Economy. He said he was told there was no way this error could be fixed.

After we contacted the Department, it accepted this wasn't fair and agreed to provide him with the broadband connection. It also connected other addresses in the area which were mistakenly missing from the list.

Case Ref: 202006512

Education

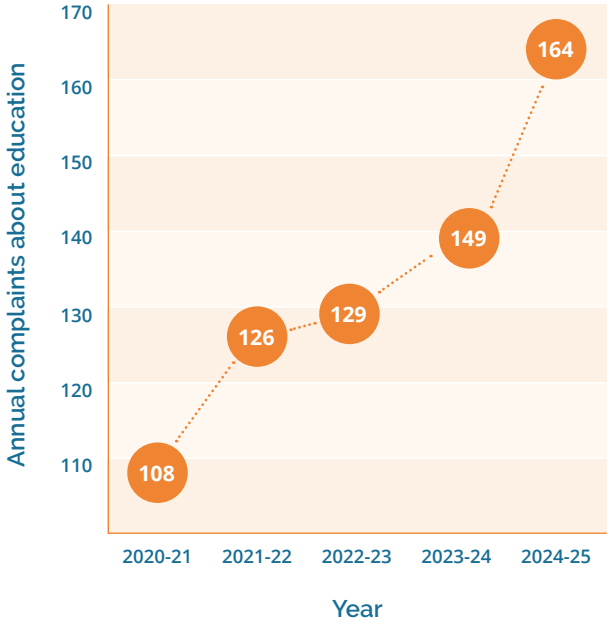
Highlighting opportunities for improvement and increased trust in public services through the investigation of complaints.

52%

increase in number of complaints schools, colleges and universities since 2020/2021.

We continue to see a rise in education related complaints with an overall increase of 52% in complaints about schools, colleges and universities since 2020/2021. This is broadly in line with the overall increase in NIPSO complaints in this period. The main themes from education complaints are often a lack of communication, a failure to fully understand and implement the complaints policy, and the understanding of the role of Boards of Governors.

When parents complain to a child's school they often express concern and fear that it may have repercussions for their child. Being able to complain effectively and also maintain relationships with a child's schools is essential. We, therefore, often work with complainants and schools to seek early resolution to maintain or repair relationships.



Breakdown of complaints received in 2024-25

	2024-25
Primary Schools	42
Post-primary schools	38
Education Authority	35
Queen's University	21
Ulster University	9
Special schools	7
Nursery schools	6
Northern Regional College	2
Council for the Curriculum, Examinations and Assessment (CCEA)	2
South West College	1
General Teaching Council for Northern Ireland	1
Total	**164**

School asked to apologise for failings over pupil's A level choices

We investigated claims from a woman who said that her son was not given enough support by his school when deciding which A levels to choose. She also said that it mismanaged his request to change subjects.

We asked the school what it had done to support the pupil when it became clear he was struggling with one of his A levels. The records provided by the school demonstrated concerns about his ability to study the subject, but there was no evidence of any support the school provided to the student, or of any meetings to discuss his struggles.

We acknowledged the impact of these failures on the student and asked the school to apologise. We also asked it to train staff on the school's policies on managing attendance and managing a request to change an A Level subject.

Case Ref: 202002913

University agrees to reconsider student's appeal

A student who failed a re-sit exam complained that Queen's University refused her appeal because she didn't submit it on time. She told us this was because of the stress she was under due to her personal circumstances.

After we contacted the University, it acknowledged that the pupil may not have been in a fit state of mind at the time and agreed to reconsider her appeal.

Case Ref: 202401693

3

Key Themes

Identifying and addressing key and overarching themes in our work

Access to Justice and Accessibility

Ombudsman offices are a significant feature of the broader legal landscape, aiming to provide an alternative path to justice depending on the remedy being sought. Our work helps to build trust between individuals and public service providers.

Our service can be accessed directly and without need for representation. This makes it easier for people to use, but we are aware that the role and value of the ombudsman may not be immediately clear. This year we have continued to focus on improving our accessibility through engagement with a wide range of voluntary and community organisations and participation in public events.

We also conducted a twelve-month project with the University of Glasgow to explore how the Ombudsman community internationally meets the needs of asylum seeking and refugee people and deepen our understanding of issues facing asylum seekers and refugees locally.

Some of the issues investigated by the Office highlighted the importance of access to justice for those who cannot advocate for themselves.

Ombudspersons and the Protection of Refugees and Asylum Seekers (OPRAS)

"A fair society means everyone should have equal access to justice and the redress it can provide, and the office of the ombudsperson is recognized as a key institution in addressing and providing equal access to justice for all, depending on the remedy sought".

Asylum seekers and refugees are among the most vulnerable groups in society and face multiple barriers in accessing public services and raising complaints. The OPRAS project, conducted in collaboration with Prof Chris Gill in the University of Glasgow explored three key areas:

- Identifying the range of strategies that are currently available to ombudspersons to effectively support asylum seekers and refugees
- Developing collaborative relationships with Civil Society Organisation and other key stakeholders to generate innovative and collaborative approaches to supporting asylum seekers and refugees
- Developing approaches to own initiative investigations and drawing on international best practice to support new approaches in Northern Ireland and beyond.

The project held workshops with policy makers, community & voluntary sector representatives and people with lived experience. An International Roundtable with Ombudspersons or their representatives and academics from 10 countries attending took place in Belfast with an end of project conference in March 2024. The project report can be found here.

Vulnerability resources

Anyone can experience vulnerability at some point in their life. People experiencing vulnerability may struggle to access and navigate public services, which in turn can lead to disadvantage. While some people may not see themselves as vulnerable, being mindful of this helps public service providers ensure that everyone's unique and individual needs are identified and met.

In June 2024 we launched a set of resources to help public service providers support people experiencing vulnerability.

The toolkit contains a Powerpoint presentation, a Workbook, Facilitator's Notes, and videos with contributions from organisations discussing their work in this area. These workshop materials aim to help organisations recognise when users need extra help to access their services. They also suggest how organisations can give support for those needs.

The materials are free to use and we are grateful to Autism NI, Barnardo's NI, the Consumer Council, the Commissioner for Victims of Crime and Dementia NI for contributing to this resource by sharing their expertise and experience in the videos which form part of the resource.

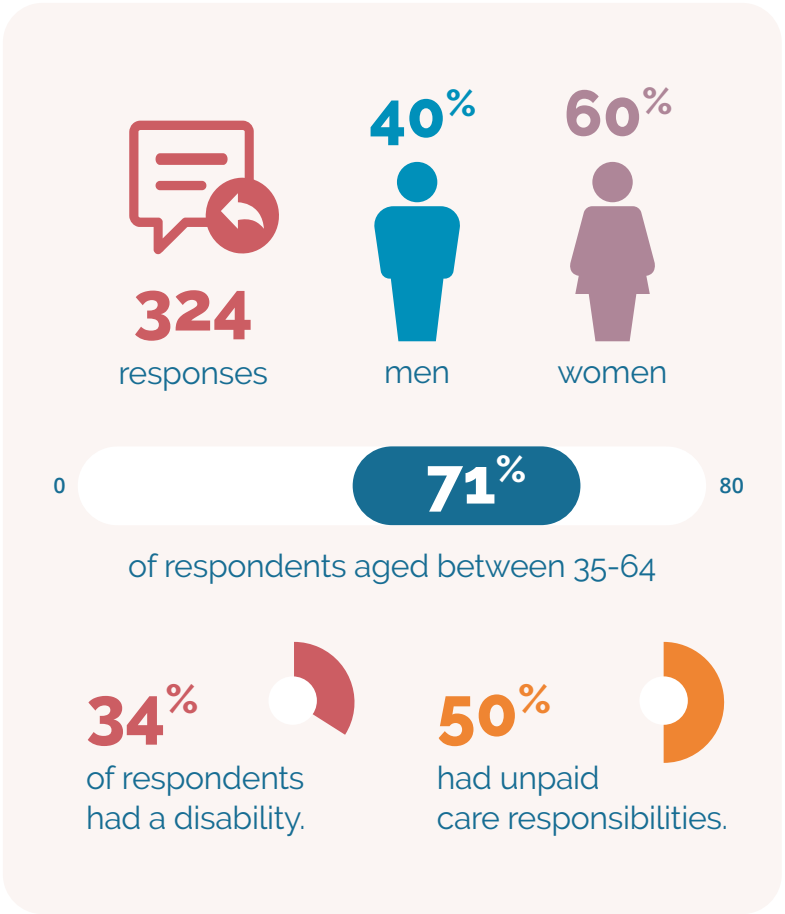
You can access the resources here.

EDI and Postcode Data

This was our second year of collecting Equality, Diversity & Inclusion data about people who bring a complaint to the Office. This voluntary survey had a response rate of 30% and provides us with some insight into the demographic make-up of complainants. This information is used to help identify groups with whom more engagement and awareness raising would be helpful.

For the third year we have also analysed the postcode data of our complainants, matching postcodes with NISRA multiple deprivation measures as a proxy for socio-economic background. This combined with the EDI data helps us better understand our complainant profile to identify whether there are groups of people or geographical areas who may be experiencing barriers or lack awareness of the Office.

This information also provides a baseline against which to monitor how diverse our reach is and whether our engagement activity and accessibility measures are having impact.



Compliance follow-up

Detailed compliance monitoring for the year 2024-25 is underway, however results for the three years between 2021 and 2024 show that out of the 858 recommendations made in our reports, 87% are reported as either complete or partially complete.

Compliance with recommendations over past three years

Failures in care of young person after move to adult services

We found serious failings in the care of a young woman with complex medical needs, whose condition deteriorated after her transition to adult services. The investigation identified poor planning, lack of oversight and absence of clear policies to support young people moving from children's to adult care.

Post-investigation the Trust conducted an audit of 20 community care plans and found inconsistent completion of initial assessments and risk evaluations with compliance at 61% in that area. The Trust committed to sharing audit findings with staff, increasing data input quality and conducting annual audits of care plans and medication records to monitor progress.

Case Ref: 202001744

Poor record-keeping during ED triage

A complainant was appropriately triaged after arrival by ambulance, but poor record keeping and communication caused distress and mistrust. The Trust accepted the failings and enhanced its triage system with online training, face to face sessions and supervised practice. Triage records are now digital, and audit results have shown improved compliance. The Trust has committed to regular bi-monthly audits to monitor consistency in triage documentation.

Case Ref: 201917280

Failings in communication

This year saw the highest ever number of recommendations relating to communication.

Communication failures meant patient had to wait too long for treatment

A man said he didn't realise the South Eastern Trust had discharged him from its mental health services. The resulting confusion left him without treatment for 18 months.

Case Ref: 202004130

Trust did not explain risks of surgery to patient

We upheld a complaint from a woman who said she did not give her consent to a surgical procedure. We also found the Trust did not follow the right procedure when it decided the case did not meet the threshold for a Serious Adverse Incident investigation.

Case Ref: 202003412

Poor communication in maternity care

The Royal Victoria Hospital, Belfast provided appropriate care and treatment to a woman in its care. However, we said that clinicians should have recorded the discussions they had with her about the progress of her labour.

As a result of our investigation the Trust updated its Induction of labour policy in line with NICE guidance, audited antenatal communication, and reminded staff of national standards. Our recommendations and the actions by the Trust strengthened their process on informed consent and provided greater clarity for expectant mothers.

This example shows how even when clinical care is sound, the importance of effective communication in ensuring patient understanding and safer, more respectful care.

Case Ref: 202002501

Media coverage of NIPSO investigations 2024-25

Watchdog slams NIHE response to complaint

Probe sparked by tenant's grievance

BY ANDREW MADDEN

The Housing Executive (NIHE) has been strongly criticised by Northern Ireland's Public Services Ombudsman (NIPSO) for repeated failures in how it handles complaints from tenants.

the matter to a 'final stage' complaint on June 14, 2023.

The NIHE agreed the issues of the complaint on June 21 and, as per its own complaints policy, should have responded to the final-stage complaint within 20 working days ... by July 19 the final-stage process." Ms Kelly said.

"I am both concerned and disappointed that as of the date of this report, the NIHE has yet to issue its final stage response. This is a delay of over 11 months. I find this delay significant

Missed by two doctors: the patient who suffered five strokes in one week

GPs criticised after man complained twice about symptoms common to condition

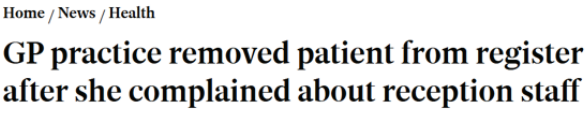
Ombudsman's report criticises Western Trust investigation

BY JOHN CARNEY

A REPORT by the Northern Ireland Public Services Ombudsman has described the Western Trust's processing of a complaint about the care given to a man who died in a local care home as "flawed" and "lacking empathy".

The Ombudsman's review was related to the process the Trust followed when it received a complaint about care provided to the complainant's mother who was a resident in a local care home. It also considered the Trust's handling of the subsequent Serious Ad-

The Western Trust's investigation of the complaint "caused great concern", the Ombudsman's report said.



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GP practice removed patient from register after she complained about reception staff

Trust issue unreserved apology for handing of man's death in Antrim

THE Northern Trust has apologised for the "failings" in the standard of care given to an 84-year-old man during the pandemic.

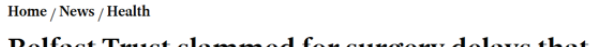
Eva Beattie died in Antrim Area second Covid vaccination, and the communication with the family regarding the positive Covid test result.

She also voiced concerns about the ability to visit or engage with her father - and the standard of her patient's rights regarding dignity and autonomy".

In a statement, the Northern Trust said: "We offer our sincere condolences to the patient's family, and we have apologised for the failings subsequently identified in

In relation to Mr Irwin's complaint, the Ombudsman upheld two and partially upheld one of the seven elements of the complaint.

Two additional failures in care and treatment were also



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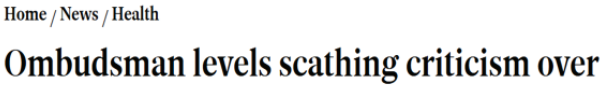
Belfast Trust slammed for surgery delays that resulted in patient dying in 'prolonged pain and distress'



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Ombudsman levels scathing criticism over Western Trust's 21-year failings of autistic boy and family

'Significant failings' in Western Trust's care of patient who died, Nipso finds

Report cites delays in transfer, pain relief and treatment of man's sepsis

By Andrew Madden

THE Western Trust has been criticised over delays in the care of a treatment of a man which contributed to his death.

manage the patient's pain appropriately, including leaving him without pain relief for nine hours, and did not insert a catheter in a timely manner, which

for the Trust, which it accepted, were that it encourages relevant staff to attend further training on providing the appropriate care to critically ill surgical patients and that it ensures staff are remind-

Own Initiative Work

During the year our Own Initiative team released a report on the provision of interpreting services in GP practices for patients who are not proficient in English.

Lost in Translation found that there were almost 11,000 requests by GP practices for an in-person interpreter in a 12-month period. However, almost half (45%) of GP practices made no requests.

It also found that, despite interpreting services being free to GP practices and patients, only 13% of practices mentioned the service on their websites, and none of them stated that they were free.

Among its 11 recommendations it suggests that the service should be promoted more widely, that interpretations should be available by phone, and that patients should be able to ask for an interpreter earlier in the process.

The team also continued to monitor how health trusts are implementing the recommendations made in our report on communicating with patients on healthcare waiting lists. A follow up report to 'Forgotten' will be released in 2026.

Ensuring learning from complaints

The impact of poor complaints handling and how we are improving complaints handling across public services.

When organisations fail to act on complaints they risk losing public trust. This is unfortunately evidenced by the findings of a number of public inquiries in Northern Ireland and across the UK. Our programme of work on Complaint Standards aims to ensure that organisations take complaints seriously, remove any barriers to complaining and use complaint data to learn and improve. This brings benefits to both the complainant and the organisation.

This year a number of investigations highlighted the impact of poor complaint handling. This not only compounds the distress of the complainant but is a drain on public service resources, as time is wasted and public trust eroded.

Housing Executive's repeated failure to deal with complaints 'deeply concerning'

Ombudsman 'cannot ignore' the Housing Executive's continued poor response to concerns raised by its service users.

Case Ref: 202004479

Report recommends review of how the Northern Ireland Housing Executive handles complaints

We upheld a man's complaint about the Housing Executive's failure to deal with his enquiries about emergency accommodation.

Case Ref: 202005280

Trust's investigation of safeguarding referral 'not sufficiently rigorous'

The South Eastern Trust should have obtained more evidence from a care home and others when it investigated an adult safeguarding referral.

Case Ref: 202005285

Trust's investigation of complaint was 'flawed and lacked empathy'

We found significant failings in the way the Western Trust investigated a woman's concerns about how her late mother was treated in a care home.

Extract from the report:
'The level of basic inaccuracies on matters of record caused me great concern. This included challenging the complainant that she did not raise the issue of bruising on her mother until after her death when written evidence clearly demonstrated this was not the case. This and other clear inaccuracies both called into question the quality of the Trust's investigation process and their empathy for someone who had just lost their mother.'

Case Ref: 202003022

4

Engagement and Impact

Engagement Team 2024/25

47
engagements with the community and voluntary sector, 16 of which focused on complaint standards work in Health and Social Care

6 engagements focused on minority ethnic communities, including asylum seekers and refugees (13%)

Community & Voluntary contact
139
individuals

47
groups

20
information events

17
University and Higher Education events

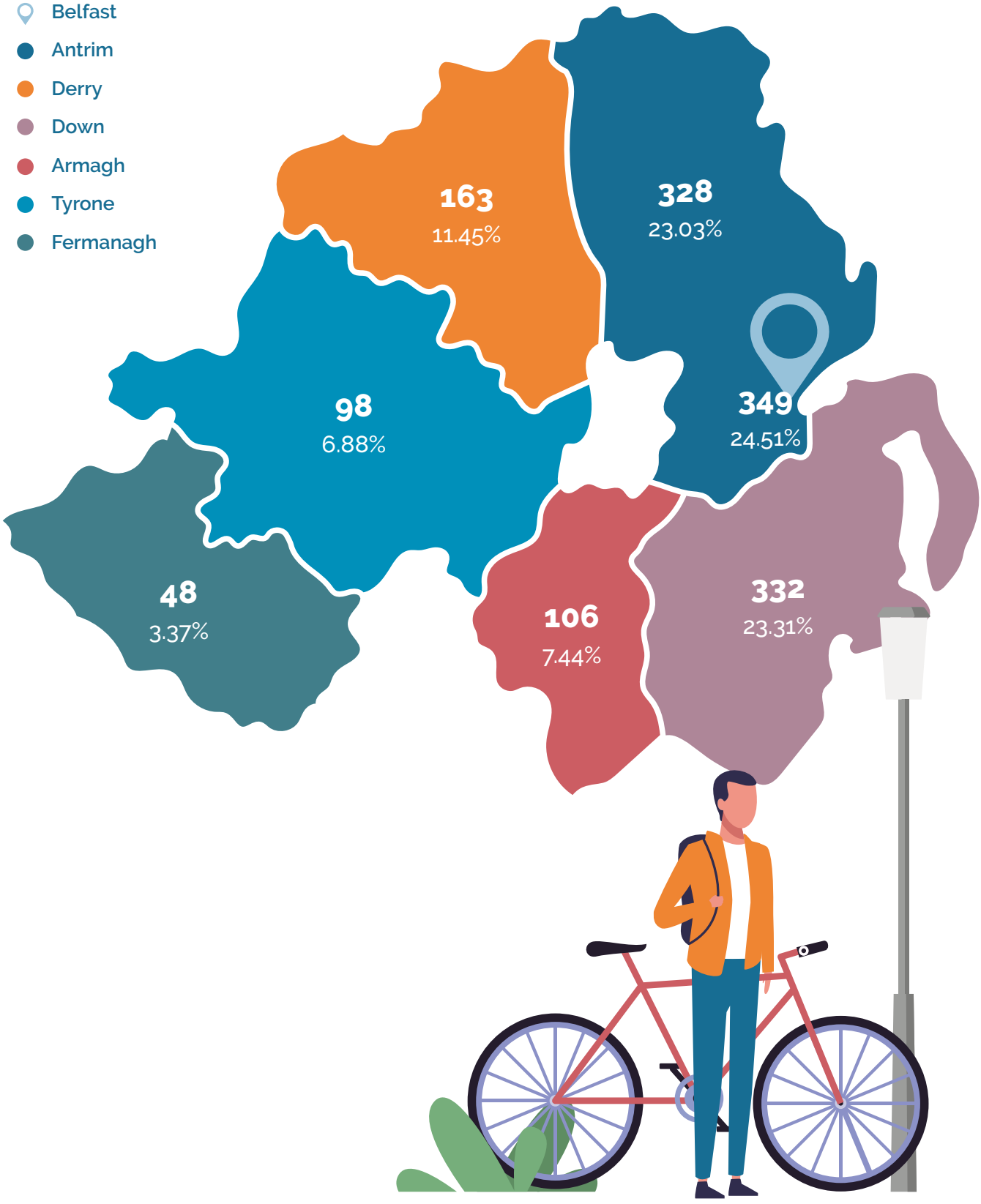
13
All-Party Group Meetings

2
case digests published

36
organisations had a health focus

Postcode Information

Our analysis of complainants' postcodes allows us to break down our cases by county of origin. The figures on the map show all cases closed during the year.



Complaints Standards

A Sectoral approach

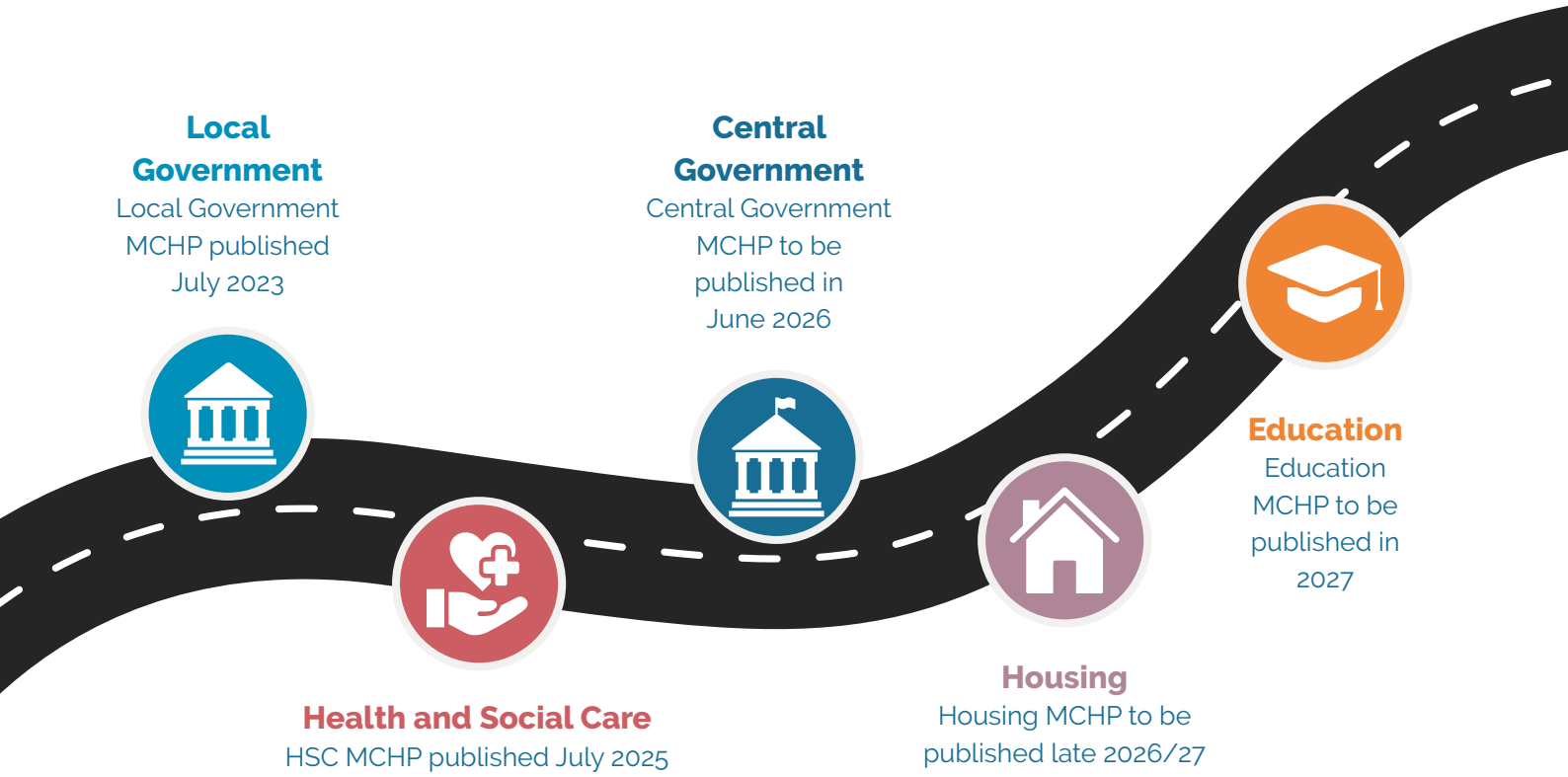
Following the publication of a model complaint handling procedure (or MCHP) for local government in 2023, in 2024 we set out an amibitious programme of work to create and implement a common set of statutory complaints standards for the remaining public bodies in Northern Ireland.

This ongoing work to streamline and standardise complaints standards and practices will ensure the public have access to justice through a simple, compassionate and accessible complaints process. These new standards will promote early resolution with a clear focus on learning from complaints to improve services and service delivery.

Our sectoral rolling programme means by mid 2027 all organisations within remit will have a published MCHP and be required to implement this new complaint standards approach.

This year saw the development of an MCHP for the whole of the health & social care sector, which was published in July 2025, with compliance a statutory requirement from January 2026. The MCHP applies to a wide range of services including hospitals, community health services, nursing homes, and family practitioner services such as GPs and dentists.

During the year we partnered with the My Home Life leadership programme to engage directly with care home managers. This collaboration brought together care home managers from across Northern Ireland. We used appreciative inquiry methods to explore the real experiences of complaints handling, which encouraged open conversations with residents, families and staff.



Ensuring the success of Complaint Standards

We recognise that to truly build a culture of learning, improvement and ownership there needs to be support for organisations. We have chosen to provide support through best practice networks, and through the development of e-learning resources and best practice guidance. In addition to monitoring compliance through our case work, we provided feedback to support best practice through the local government network. At these quarterly network meetings we provided direction on the requirement to report and publish complaints data, with a particular focus on demonstrating learning and service improvement through complaints.

Best Practice Networks

Compliance

Reporting and Publishing

To further support all public sector organisations in ensuring that their staff, at every level, know their role and feel equipped to implement the new standards to effectively manage complaints, we developed best practice guidance and ten bite sized videos which deliver clear and consistent messaging on the new requirements for frontline staff and management.

We also commissioned work on the development of eight e-learning modules which will be launched in March 2026. These can be accessed here.

An Introduction to Good Complaints Handling

How to Investigate Complaints at Stage One

How to Investigate Complaints at Stage Two (Part One) - The Process

How to Investigate Complaints at Stage Two (Part Two) - Skills and Tips

How to Record Complaint Outcomes

How to Make and Communicate Good Decisions

HSC Stakeholder Engagements

Northern Ireland Judicial Appointments Ombudsman

The role of Judicial Appointments Ombudsman was created by the statutory framework set out in the Justice (Northern Ireland) Act 2002 and provides an independent and external element for those persons who wish to complain about any administrative aspect of their own experience as applicants during an appointment process for judicial office.

A wide-ranging review of the criminal justice system in Northern Ireland concluded in March 2000. One of its recommendations included the appointment of a person to oversee, monitor and audit the existing appointment procedures for judicial roles. This in turn led to the creation of the role of Commissioner for Judicial Appointments who carried out a review of the existing processes for appointing judges.

Following the passage of legislation, this resulted in the establishment in Northern Ireland of Northern Ireland Judicial Appointments Commissioner (NIJAC) in 2005 and the Northern Ireland Judicial Appointments Ombudsman (NIJAO) in 2006. The 2002 Act provided the statutory framework for the establishment of the Northern Ireland Judicial Appointments Ombudsman.

Sections 9A to 9H of the 2002 Act defined the arrangements for investigating complaints which were made to both NIJAC and to the Judicial Appointments Ombudsman respectively and how they were to be reported. The 2002 Act provides for the Judicial Appointments Ombudsman to submit a report at the conclusion of each financial year.

Following the devolution of policing and justice matters to the Northern Ireland Assembly in April 2010, such reports were laid by the Minister of Justice before the Assembly. However, the legislation governing the procedures for laying a report were amended by the Public Services Ombudsman Act (Northern Ireland) Act 2016 (the 2016 Act) to provide for the report to be laid before the Assembly by the Ombudsman.

As Ombudsman I act as Northern Ireland Judicial Appointments Ombudsman, dealing with complaints of maladministration in respect of judicial appointments. During 2024-25 one complaint was received (2023:24: one complaint). It was determined to have not been submitted within the designated timescale.

Northern Ireland
Public Services
Ombudsman

Northern Ireland Public Services Ombudsman

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