Northern Ireland Ombudsman

Annual Report

of the Assembly Ombudsman for Northern Ireland and the
Northern Ireland Commissioner for Complaints

2011–2012

My Role

The title of Northern Ireland Ombudsman is the popular name for two offices:

The Assembly Ombudsman for Northern Ireland: and
The Northern Ireland Commissioner for Complaints.

I deal with complaints from people who claim to have suffered injustice because of maladministration by government departments and agencies and a wide range of other public bodies in Northern Ireland.

The term "maladministration" is not defined in my legislation but is generally taken to mean poor administration or the wrong application of rules.

The full list of bodies which I am able to investigate is available on my website (www.ni-ombudsman.org.uk) or by contacting my Office (tel: 028 9023 3821). It includes all the Northern Ireland government departments and their agencies, local councils, education and library boards, Health and Social Care Trusts, housing associations, and the Northern Ireland Housing Executive.

As well as being able to investigate both Health and Social Care, I can also investigate complaints about the private health care sector but only where Health and Social Care are paying for the treatment or care. I do not get involved in cases of medical negligence nor claims for compensation as these are matters which properly lie with the Courts.

I am independent of the Assembly and of the government departments and public bodies which I have the power to investigate. All complaints to me are treated in the strictest confidence. I provide a free service.

ANNUAL REPORT of the ASSEMBLY OMBUDSMAN for NORTHERN IRELAND and the NORTHERN IRELAND COMMISSIONER for COMPLAINTS for 2011/12

Presented to the Assembly pursuant to Article 17 of the Ombudsman (Northern Ireland) Order 1996 and Article 19 of the Commissioner for Complaints (Northern Ireland) Order 1996

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Section One

The Year in Review

The Year in Review

I am pleased to lay my eleventh Annual Report before the Northern Ireland Assembly in accordance with the statutory requirements of the Assembly Ombudsman and Commissioner for Complaints legislation. This report, as the document of record, outlines the core functions of my office for the year 2011/12. A key function of the office is the investigation of complaints of mal-administration about the actions of bodies from across the public sector in Northern Ireland as well as general health service bodies. Therefore the investigations I have undertaken during the period being reported on relate to complaints raised with me by Members of the Northern Ireland Assembly as well as the individual citizen. The breadth of my jurisdiction is such that I consider complaints about matters including planning, health, social care, housing and education. With the devolution of policing and justice powers to the Assembly in April 2010, my jurisdiction was extended to cover complaints about a range of justice bodies. Given this wide jurisdiction, I have a unique insight into the administrative performance of public administration in Northern Ireland and how it affects the lives of the citizens we serve.

The Constitutional Role of the Ombudsman

Ombudsman is a Swedish word meaning a 'trusted official' who is charged with the investigation of complaints about governmental and public bodies. In doing so the Ombudsman acts on behalf of the legislature and in Northern Ireland I am one of the three statutory officers of the Northern Ireland Assembly along with the Comptroller and Auditor General and the Examiner of Statutory Rules. It is appropriate therefore that I report formally in this document on the activities of my office to the Assembly given my constitutional relationship with that body.

Proposals to Reform and Update the Ombudsman Legislation

In my annual report last year I referred to the work of the OFMDFM Committee under the previous mandate in sponsoring new legislation to revise the legislative arrangements which currently underpin the work of my office. The Ombudsman is an essential part of the architecture of accountability in Northern Ireland and I am pleased to record that the present OFMDFM Committee has built upon the original work and is developing clear proposals for refreshing existing legislation. Both my Deputy and I have attended the Committee on a number of occasions during the reporting year to answer questions as the matter has progressed.

The Ombudsman in continuing adverse economic conditions

The continuing adverse economic climate creates a greater demand on public services at a time when the public sector as a whole is having to make hard choices in the context of shrinking budget resources. At such times, the needs of individual citizens and the quality of the delivery of public services come under intense pressure. It is my view that when public servants are under pressure to deliver 'more with less', front line services can suffer and errors and omissions are more likely to occur. In this reporting year, as Ombudsman I have an important role to play to ensure the impartial investigation of citizen's grievances and, where appropriate, the remedying of those grievances. In the process I believe that I can assist in rebuilding, in some cases, lost trust and confidence in the public services commitment to do the right thing.

Overall complaints to my office have decreased slightly this year. However, the sectoral picture differs and there is a continuing upward trend of complaints about health and social care – an

increase of 12% overall in this reporting period. Complaints about justice bodies has risen by 12.5%, as well as complaints about NIHE and Planning Service, and both my staff and I have been concentrating outreach activity in this area so as to better inform those bodies of my role in their approach to complaints handling. Of concern is the rise in complaints relating to employment matters. A rise of 29% demonstrates, in my view, the effect of the downturn of individuals in the workplace.

During the year I provided the Assembly with two digests of anonymised cases as well as my Annual Report. These case summaries allow Members an insight into how different parts of the public service are performing. I consider this is important because the complaints I investigate can highlight good practice and also the systemic improvements that are needed to ensure public bodies meet their primary objectives of delivering fair, effective and high quality public services. Importantly for public officials, my investigation reports continue to acknowledge good practice, for example, in a recent case, involving the Oaklee Homes Group (Oaklee), the Chief Executive went beyond the scope of my recommendation in applying the financial remedy recommended to other affected tenants. In this case the complainant was aggrieved that the weekly support charge did not reduce in accordance with the reduced support service provided to her. I identified maladministration by Oaklee in failing to reduce the support charge during a period when the support was reduced and in failing to provide the complainant with clear and adequate responses during Stages 1 and 2 of the complaints process. I recommended that Oaklee offer a comprehensive apology and make a payment of £500 to the complainant. I commend the Chief Executive for his proactive approach in seeking to provide redress to other similarly affected tenants.

My case summaries also record the complaints that have not been upheld and so ensure that bodies have a 'shield' against unfair criticism or unreasonable complaints particularly at a time of reducing public resources and heightened public expectations of services.

Commentaries

In the areas of Housing, Planning, Health and Social Care commentaries are provided in later sections of this Report.

Records Management

The process undertaken by my office when investigating a complaint regularly involves the examination of the records of the case held by the Government Department or Public Body concerned. It was therefore a matter of extreme concern to me to discover this year that a particular agency (the Education and Training Inspectorate (ETI)), as a matter of practice, destroyed the basic notes made during its inspections as soon as a report had been drafted. I considered this practice unfair to any person who might be criticised by the report as it effectively denied such an individual the right of natural justice to question and explore the detail of the matter which gave rise to the criticism. The practice also effectively meant that when an individual had their case referred to me – and by law that could be up to one year after they learned of the matter that was the cause of their grievance – I was seriously inhibited in conducting an investigation. I had no hesitation in deciding that this practice constituted maladministration. I am happy to report that this practice has now ceased.

Whilst it is an extreme example, the case highlights the need for good records management and in particular the need to retain, where necessary, for organisational purposes, records made in respect of public service matters.

The case had a further important impact, highlighting the differing roles of the Ombudsman and the judge. Subsequent to the issue of my report to the parties Mr Justice McCloskey prepared and issued a preface to his judgement in a related judicial review application, in which he stated:

"The attention of the court has now been drawn to the report of the Northern Ireland Ombudsman, published on 10th January 2012. This report concludes that, in the conduct of its inspection, culminating in the aforementioned report, ETI

committed several instances of maladministration. Amongst other recommendations, the Ombudsman recommended that since the ETI assessment "cannot be relied upon", the report should not be published [10/02/12]. While this has no impact on the substance of the court's decision, fairness to the Plaintiff dictates that the court draw attention to this post-litigation development."

Whilst the courts consider the legality of decisions, the Ombudsman considers the decision making process and where appropriate recommends corrective action to be taken.

Conclusion

I am pleased to report that in the vast majority of cases my recommendations as to remedy and action to improve administrative practice have been accepted by the Government Departments, Public Bodies and other organisations within my jurisdiction. Whilst my initial focus in a case is to identify the facts and identify if maladministration occurred, I will always look, in addition, at the administrative practices associated with the complaint. I believe firmly that there is always benefit in reviewing the administrative process and it is encouraging that across the wide range of organisations within my jurisdiction such a positive attitude is shown to my recommendations for improvement in this regard. I continue to remind bodies of the Principles of Good Administration when reporting on individual complaints. These principles are a benchmark for all bodies in my jurisdiction against which to measure their administrative practices. A summary of the Principles of Good Administration is provided in Appendix D.

Number of Contacts 2011/12

Written Complaints – **640**
Telephone Calls – **1294**
Interviews – **43**

Breakdown of Telephone Calls to the Office 2011/12

Assembly Ombudsman – **137**
Commissioner for Complaints – **149**
Health and Social Care – **180**
Outside Jurisdiction – **828**

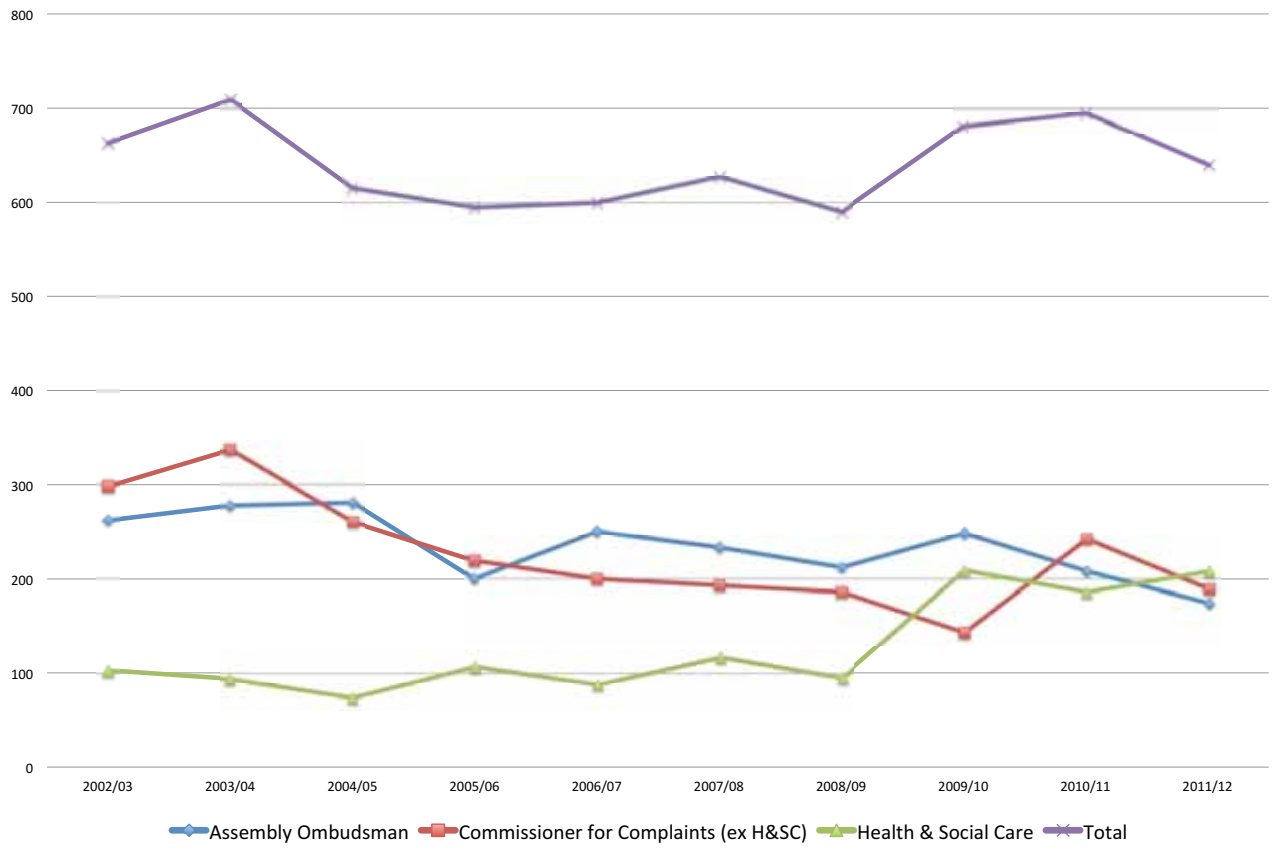
Breakdown of Interviews in the Office 2011/12

Assembly Ombudsman – **8**
Commissioner for Complaints – **16**
Health and Social Care – **16**
Outside Jurisdiction – **3**

Breakdown of Written Complaints to the Office 2011/12

Assembly Ombudsman – **174**
Commissioner for Complaints – **189**
Health and Social Care – **208**
Outside Jurisdiction – **69**

Complaints Received 2002/03 - 2011/12



Section Two

Annual Report of the
Assembly Ombudsman for Northern Ireland

In my role as Assembly Ombudsman, I investigate complaints of maladministration against government departments and their agencies. I received a total of 174 complaints of maladministration during 2011/12, 34 less than in 2010/11. When their respective agencies are included, the **Department of the Environment** and the **Department of Finance and Personnel** attracted most complaints, 60 against the former and 27 against the latter. Of these, 40 related to their agencies, with **Land and Property Service** (21) and **Driver and Vehicle Agency** (18), giving rise to the largest number of complaints. In all, 79 of the 173 complaints received in 2011/12 related to the agencies of government departments.

Planning Service

From 1 April 2011 Planning Service's status as an agency ended and its functions were absorbed into the Department of the Environment. It became known as the Planning and Local Government Group (DOE). The aim of the restructuring was to prepare the Planning Service for the anticipated transfer of planning powers to local government in Northern Ireland.

The number of complaints I received about the actions of the newly formed Planning and Local Government Group showed a small increase on the previous year's complaints against the former Planning Service and the majority of the complaints were submitted by objectors to the granting of planning approval. The legislation governing my office does not give me the authority to question discretionary decisions and, as I have highlighted before, my jurisdiction in planning matters is limited and extends only to the investigation of the administrative actions that inform the decisions of the Planning and Local Government Group. Importantly, disagreement with a planning decision does not in itself constitute evidence of maladministration, which I appreciate can be a difficult concept for complainants to accept.

In previous annual Reports, I have commented on the shortcomings I had identified in the performance of the former Planning Service when dealing with complaints. During the year my staff have continued to engage with staff from the Planning and Local Government Group to review progress on matters raised in complaints. I also met with the Minister in September 2011 and appeared before the DOE Planning Committee in December 2011 to discuss these issues.

I welcome the fact that a new complaints procedure was launched by Planning and Local Government Group in January 2012 and that greater access is now available to citizens via the website on information regarding planning applications. The number of cases of maladministration reduced from 8 in the previous year to 2 this year. In addition, 2 cases were settled without the need for detailed investigation, which was the same number as the previous year. This demonstrates a willingness to seek an early resolution when failures occur.

Decisions taken in relation to planning have an impact on the quality of lives of many citizens in Northern Ireland and I still continue to receive complaints where the individual feels that the lack of detail supporting decisions left them feeling their objections were not fully considered. I also receive complaints about lack of enforcement and breaches of planning approval. Good administration by public bodies means that keeping proper and appropriate records and, stating its criteria for decision making and giving reasons for decisions, will assist in giving explanations to complainants that are more detailed and with the rationale clearly identified. It is my view that such an approach would help provide an insight, and therefore a better understanding of the reasoning behind a planning decision and would provide more confidence in the administrative process.

I will continue to monitor progress in these areas through complaints received by my office.

Statistics

Caseload for 2011/12

A total of 174 complaints were received during 2011/12, 34 less than in 2010/11.

Cases brought forward from 2010/11	29
Written complaints received	174
Total Caseload for 2011/12	**203**
of which:	
Cleared at Validation Stage	132
Cleared at Investigation Stage (without a Report), including cases withdrawn and discontinued	18
Settled	2
Full Report or Letter of Report issued to MLA	18
Ongoing at 31/03/12	33

Written Complaints Received in 2011/12 by Authority Type

Government Departments	94
Agencies of Government Departments	79
Tribunals	0
North/South Implementation Bodies	1

Written Complaints Received in 2011/12 by Complaint Subject

Agriculture	**8**
Benefits	**10**
Child Support	**9**
Education	**2**
Environment	**17**
Miscellaneous	**26**
Personnel	**28**
Planning	**43**
Rates	**16**
Roads	**14**
Water	**1**

Recommendations in Reported and Settled Cases

Case No	Body	Subject of Complaint	Recommendation
200800835	Department of the Environment (Planning and Local Government Group)	Planning Application	Written apology & payment of £4,000. Production of a public information leaflet.
200900802	Department for Social Development - CMED	Child Maintenance	Written apology & payment of £1,000.
200900877	Roads Service	Development & Alteration of Roads	Written apology & payment of £1,000.
201000059	Department of Education (Education and Training Inspectorate)	Policy & Procedure	Written apology & review of process.
201000113	Rivers Agency	Complaints Handling & Administration	Written apology, payment of £3,000 & review of process.
201000250	Ulster-Scots Agency	Grant Funding	Written apology.
201000567	Department of Agriculture and Rural Development	Complaints Handling & Administration	Written apology & payment of £500.
201000822	Department of the Environment (Planning and Local Government Group)	Planning Application	Written apology & payment of £1,000.
201000840	Northern Ireland Environment Agency	Complaints Handling & Administration	Written apology & payment of £500.
201000854	Department of Agriculture and Rural Development	Personnel – Complaints Handling	Written apology.
201001306	Department for Employment and Learning	Personnel – Grievance	Written apology.
201100108	Department of the Environment (Planning and Local Government Group)	Policy & Procedure - Vesting	Settled during investigation. Written apology & payment of £5,000.
201100273	Department of the Environment (Planning and Local Government Group)	Planning Application	Written apology & payment of £750.

Analysis of Written Complaints Received in 2011/12

	Brought forward from 2010/11	Received	Cleared at Validation Stage	Settled	Cleared at Investigation Stage	Report Issued Complaint Upheld/ Partially Upheld	Report Issued Complaint Not Upheld	Ongoing at 31/03/12
Government Departments	24	94	74	2	7	7	7	21
Agencies of Government Departments	5	79	58	0	11	4	0	11
Tribunals	0	0	0	0	0	0	0	0
North / South Implementation Bodies	0	1	0	0	0	0	0	1
TOTAL	**29**	**174**	**132**	**2**	**18**	**11**	**7**	**33**

Analysis of Written Complaints Against Government Departments

	Brought forward from 2010/11	Received	Cleared at Validation Stage	Settled	Cleared at Investigation Stage	Report Issued Complaint Upheld/ Partially Upheld	Report Issued Complaint Not Upheld	Ongoing at 31/03/12
DARD	5	8	8	0	3	2	0	0
DCAL	0	0	0	0	0	0	0	0
DE	2	5	3	0	1	1	1	1
DEL	1	1	0	0	0	1	0	1
DETI	1	4	4	0	0	0	0	1
DFP	1	5	5	0	0	0	1	0
DHSSPS	0	2	1	0	1	0	0	0
DOE	1	0	0	0	0	0	1	0
DOE (P&LGG)	11	42	28	2	2	2	3	16
DRD	1	4	4	0	0	0	1	0
DSD	0	7	7	0	0	0	0	0
DSD (CMED)	1	9	9	0	0	1	0	0
OFMDFM	0	0	0	0	0	0	0	0
DOJ	0	7	5	0	0	0	0	2
TOTAL	**24**	**94**	**74**	**2**	**7**	**7**	**7**	**21**

Analysis of Written Complaints Against Agencies of Government Departments

	Brought forward from 2010/11	Received	Cleared at Validation Stage	Settled	Cleared at Investigation Stage	Report Issued Complaint Upheld/ Partially Upheld	Report Issued Complaint Not Upheld	Ongoing at 31/03/12
Driver Vehicle Agency	0	18	16	0	2	0	0	0
NI Environment Agency	1	1	1	0	0	1	0	0
Land & Property Services	0	21	12	0	5	0	0	4
Planning Service*	0	0	0	0	0	0	0	0
Rivers Agency	1	2	1	0	0	1	0	1
Roads Service	1	10	7	0	1	1	0	2
Social Security Agency	0	11	10	0	1	0	0	0
NI Prison Service	0	3	2	0	0	0	0	1
NI Courts & Tribunal Service	1	6	5	0	1	0	0	1
General Register Office	0	1	1	0	0	0	0	0
Compensation Agency	0	1	0	0	0	0	0	1
Ulster-Scots Agency	1	0	0	0	0	1	0	0
Appeals Service	0	1	0	0	0	0	0	1
Health Estates Agency	0	1	1	0	0	0	0	0
Public Record Office NI	0	3	2	0	1	0	0	0
TOTAL	**5**	**79**	**58**	**0**	**11**	**4**	**0**	**11**

* Now recorded as DOE (P&LGG)

Analysis of Written Complaints Against North/South Implementation Bodies

	Brought forward from 2010/11	Received	Cleared at Validation Stage	Settled	Cleared at Investigation Stage	Report Issued Complaint Upheld/ Partially Upheld	Report Issued Complaint Not Upheld	Ongoing at 31/03/12
Special European Union Programmes Body	0	1	0	0	0	0	0	1
TOTAL	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**1**

Section Three

Annual Report of the
Northern Ireland Commissioner for Complaints
(excluding Health and Social Care Complaints)

The remit of the Commissioner for Complaints (NI) Order 1996 extends to most public bodies in Northern Ireland. Under this Order, I receive complaints about local councils, the Housing Executive and housing associations, and the education and justice sectors. The number of complaints against the Housing Executive increased slightly this year, however I continue to see willingness from the Housing Executive to engage with my Office in resolving complaints which have been received by me.

I am pleased to note that there has been a 50% reduction in the number of complaints about registered Housing Associations. I consider this is reflective of the efforts made by the Housing Association sector to improve their complaints handling process. In a recent case, I investigated a complaint from a tenant of the Oaklee Homes Group (Oaklee) who was aggrieved that the weekly support charge did not reduce in accordance with the reduced support service provided to her. Following investigation I identified maladministration by Oaklee in failing to reduce the support charge during a period when the support was reduced and in failing to provide the complainant with clear and adequate responses during Stages 1 and 2 of the complaints process. I recommended that Oaklee offer a comprehensive apology and make a payment of £500 to the complainant. I am pleased to record that the Chief Executive accepted my recommendations. I also commend the Chief Executive who went beyond the scope of my recommendation in his intention to make an appropriate payment to other residents in the same scheme who were similarly affected.

This year there has been an increase in complaints against local councils overall which is not apparent at first consideration of the figures. I referred in my Annual Report last year to a case where a complainant gained support for their complaint by setting up a website which encouraged supporters to complain directly to me on the issue complained of. This action resulted in a large increase in the number of complaints made against Councils. When numbers attributable to this complaint are discounted from last year's total complaints received, it is clear that an increase in complaint against Councils is in excess of 32%.

Of particular significance this year is a case involving North Down Borough Council. This complaint in particular demonstrated that a finding of maladministration made against a particular Council has the potential to have implications across the sector. In this case the complainant, a landscape gardener, disposed of domestic garden waste at North Down Borough Council's Recycling Centre on two occasions. He was charged on both occasions as a commercial user. Although he received a refund of the charges from the Council he remained unhappy about how his complaint was handled and the lack of apology from the Council. I upheld the complaint of maladministration and recommended an apology and a payment of £250.

During the course of my investigation, I identified that the Council had no legislative authority to charge for the deposit of household waste, irrespective of who delivers it to the recycling centre. I noted with concern that the Council had been charging commercial users such as the complainant to dispose of household waste when they had no authority to do so. The decision to charge or not for the deposit of waste must be based on the nature of the waste and the Council should make decisions on whether to accept the waste or charge for it on a case-by-case basis and not by reference to any blanket policy or the particular business of the person delivering the waste. I recommended that the Council should make arrangements to advise members of the public that no charge would be levied by the Council for the disposal of "household waste" and that a refund should be offered to those users of the recycling facility who had been incorrectly charged. I am pleased to note that the Council followed this recommendation.

As anticipated in last year's Annual Report, following the devolution of policing and justice powers I continue to receive complaints in relation to arms length justice bodies in this sector. An emerging theme in relation to this sector is that many complaints refer to the handling of employment related activities, including the handling of disciplinary, grievance and absence matters.

Statistics

Caseload for 2011/12

A total of 189 complaints were received during 2011/12, 53 less than in 2010/11

Cases brought forward from 2010/11	29
Written complaints received	189
Total Caseload for 2011/12	218
of which:	
Cleared at Validation Stage	135
Cleared at Investigation Stage (without a Report), including cases withdrawn and discontinued	31
Settled	7
Full Report or Letter of Report issued to MLA	21
Ongoing at 31/03/12	24

Written Complaints Received in 2011/12 by Authority Type

Local Councils	60
Education Authorities	16
Health and Social Care Bodies*	33
Registered Housing Associations	11
Northern Ireland Housing Executive	46
Other Bodies Within Jurisdiction	23

*My Office continued to deal with cases which had arisen prior to the introduction of the new HSC complaints procedure in 2009.

Written Complaints Received in 2011/12 by Complaint Subject

Building Control	7
Education	4
Environmental Health & Cleaning	12
Housing	51
Land & Property	5
Personnel	74
Recreation & Leisure	10
Miscellaneous	26

Recommendations in Reported and Settled Cases

Case No	Body	Subject of Complaint	Recommendation
200701064	Southern Education & Library Board	Special Educational Needs	Written apology & payment of £2,000.
200801252	North Down Borough Council	Environmental Health – Complaints Handling & Administration	Written apology, payment of £250 & review of process.
201000503	Derry City Council	Policy & Procedure	Written apology & payment of £400.
201000509	Northern Ireland Housing Executive	Housing – Outstanding Repairs	Written apology.
201000682	Belfast Health & Social Care Trust	Personnel – Complaints Handling & Recruitment	Written apology & payment of £750.
201000683	Probation Board for Northern Ireland	Personnel - Grievance	Written apology.
201001357	Northern Ireland Housing Executive	Housing – Complaints Handling & Outstanding Repairs	Written apology & action taken by body.
201100122	Oaklee Homes Group	Housing – Rent & Service Charges	Written apology, payment of £500 & review of process.
201100135	Agri-Food and Biosciences Institute	Personnel – Pay & Superannuation	Written apology, payment of £300 & review of process.
201100343	North Down Borough Council	Environmental Health - Animals	Written apology & payment of £150.
201100368	Western Health & Social Care Trust	Personnel – Policy & Procedure	Written apology, payment of £200 & review of process.
201100369	Western Health & Social Care Trust	Personnel – Policy & Procedure	Written apology, payment of £200 & review of process.
201100371	Western Health & Social Care Trust	Personnel – Policy & Procedure	Written apology, payment of £200 & review of process.
201100543	Craigavon Borough Council	Personnel - Grievance	Written apology, payment of £150 & review of process.
201100862	Down District Council	Building Control & Complaints Handling	Payment of £250.
201100870	Northern Ireland Housing Executive	Housing – Complaints Handling	Payment of £100.

Analysis of Written Complaints Received in 2011/12

	Brought forward from 2010/11	Received	Cleared at Validation Stage	Settled	Cleared at Investigation Stage	Report Issued Complaint Upheld/ Partially Upheld	Report Issued Complaint Not Upheld	Ongoing at 31/03/12
Local Councils	5	60	42	1	10	3	2	7
Education Authorities	3	16	16	0	1	1	0	1
Health & Social Care Boards	10	33	17	3	9	1	4	9
Housing Authorities	4	57	41	3	8	2	2	5
Other Bodies Within Jurisdiction	7	23	19	0	3	2	4	2
TOTAL	**29**	**189**	**135**	**7**	**31**	**9**	**12**	**24**

Analysis of Written Complaints Against Education Authorities

	Brought forward from 2010/11	Received	Cleared at Validation Stage	Settled	Cleared at Investigation Stage	Report Issued Complaint Upheld/ Partially Upheld	Report Issued Complaint Not Upheld	Ongoing at 31/03/12
North Eastern E&LB	1	4	4	0	1	0	0	0
South Eastern E&LB	0	6	6	0	0	0	0	0
Southern E&LB	2	1	1	0	0	1	0	1
Western E&LB	0	4	4	0	0	0	0	0
CCEA	0	1	1	0	0	0	0	0
CCMS	0	1	1	0	0	0	0	0
TOTAL	**3**	**17**	**17**	**0**	**1**	**1**	**0**	**1**

Analysis of Written Complaints Against Local Councils

	Brought forward from 2010/11	Received	Cleared at Validation Stage	Settled	Cleared at Investigation Stage	Report Issued Complaint Upheld/ Partially Upheld	Report Issued Complaint Not Upheld	Ongoing at 31/03/12
Ards BC	0	1	1	0	0	0	0	0
Armagh C&DC	1	0	0	0	0	0	0	1
Ballymoney BC	1	1	1	0	1	0	0	0
Banbridge DC	0	1	1	0	0	0	0	0
Belfast CC	0	10	9	0	0	1	0	0
Carrickfergus BC	0	6	4	0	0	0	0	2
Craigavon BC	0	5	4	0	0	1	0	0
Derry CC	1	6	4	0	2	1	0	0
Down DC	1	6	1	1	4	0	0	1
Dungannon & South Tyrone BC	0	2	2	0	0	0	0	0
Larne BC	0	6	4	0	1	0	0	1
Lisburn CC	0	5	3	0	1	0	0	1
Magherafelt DC	0	1	1	0	0	0	0	0
Newry & Mourne DC	0	2	2	0	0	0	0	0
Newtownabbey BC	0	3	3	0	0	0	0	0
North Down BC	1	2	1	0	0	0	2	0
Omagh DC	0	1	1	0	0	0	0	0
Strabane DC	0	2	0	0	1	0	0	1
TOTAL	**5**	**60**	**42**	**1**	**10**	**3**	**2**	**7**

Analysis of Written Complaints Against Health and Social Care Bodies

	Brought forward from 2010/11	Received	Cleared at Validation Stage	Settled	Cleared at Investigation Stage	Report Issued Complaint Upheld/ Partially Upheld	Report Issued Complaint Not Upheld	Ongoing at 31/03/12
Belfast Health & Social Care Trust	3	10	4	0	3	1	1	4
Business Services Organisation	0	4	2	0	0	0	0	2
Northern Health & Social Care Board	1	0	0	0	0	0	1	0
Northern Health & Social Care Trust	2	4	3	0	1	0	0	2
NI Ambulance Service Trust	0	1	0	0	1	0	0	0
Regulation & Quality Improvement Authority	1	1	0	0	0	0	1	1
South Eastern Health & Social Care Trust	0	4	2	0	2	0	0	0
Southern Health & Social Care Trust	1	3	3	0	1	0	0	0
Western Health & Social Care Trust	2	6	3	3	1	0	1	0
TOTAL	**10**	**33**	**17**	**3**	**9**	**1**	**4**	**9**

Analysis of Written Complaints Against Housing Authorities

	Brought forward from 2010/11	Received	Cleared at Validation Stage	Settled	Cleared at Investigation Stage	Report Issued Complaint Upheld/ Partially Upheld	Report Issued Complaint Not Upheld	Ongoing at 31/03/12
Northern Ireland Housing Executive	3	46	32	3	7	1	1	5
Alpha Housing Association (NI) Ltd	0	1	1	0	0	0	0	0
Apex Housing	0	1	1	0	0	0	0	0
Clanmill Housing Association Ltd	0	0	0	0	0	0	0	0
Fold Housing Association	1	1	1	0	0	0	1	0
Habinteg Housing Association (Ulster) Ltd	0	3	2	0	1	0	0	0
Oaklee Homes Group	0	2	1	0	0	1	0	0
Triangle Housing Association Ltd	0	2	2	0	0	0	0	0
Trinity Housing	0	1	1	0	0	0	0	0
TOTAL	**4**	**57**	**41**	**3**	**8**	**2**	**2**	**5**

Analysis of Written Complaints Against Other Bodies Within Jurisdiction

	Brought forward from 2010/11	Received	Cleared at Validation Stage	Settled	Cleared at Investigation Stage	Report Issued Complaint Upheld/ Partially Upheld	Report Issued Complaint Not Upheld	Ongoing at 31/03/12
Agri-Food and Sciences Institute	0	1	0	0	0	1	0	0
Arts Council	1	0	0	0	0	0	1	0
Health & Safety Executive	0	1	1	0	0	0	0	0
Labour Relations Agency	0	3	3	0	0	0	0	0
NI Fire & Rescue Service	0	6	4	0	1	0	0	1
NI Legal Services Commission	1	4	2	0	1	0	1	1
NI Policing Fund	0	2	1	0	1	0	0	0
NI Policing Board	4	2	4	0	0	0	2	0
Probation Board for NI	1	1	1	0	0	1	0	0
Sport NI	0	1	1	0	0	0	0	0
Unspecified Body	0	1	1	0	0	0	0	0
TOTAL	**7**	**22**	**18**	**0**	**3**	**2**	**4**	**2**

Section Four

Annual Report of the
Northern Ireland Commissioner for Complaints
Health and Social Care Complaints

This year has seen a 12% increase in the total number of health and social care complaints received by my Office when compared to the number received in the same period last year. Sixty percent (125) of these cases were not accepted for investigation for a number of reasons, with the primary reason being that the case was premature, i.e. the complaint had not been put to the relevant health and social care body in the first instance to be considered under the Health and Social Care complaints procedure. Last year I noted my commitment to reducing the number of cases received by my Office which were premature through the use of effective outreach strategies. I am pleased to note a reduction of 7% in the number of cases received and not accepted by my Office on the grounds of 'prematurity'.

Assisting complainants with enquiries and 'in person' complaints, whilst having fallen in frequency this year by 23% continue to represent a major part of the activity of my Office, with 196 enquiries or 'in person' complaints being dealt with.

I am also pleased to note, and building on efforts last year to reduce the number of cases that exceeded one year, the office has continued to report on more cases within year representing a rise of 22% (11) in this area. A total of 59 cases were reported on, which represented 60% of the total cases reported on by my Office as a whole. A significantly greater number of cases were also cleared after a preliminary investigation was undertaken, as opposed to a detailed investigation. This represented a 190% increase, with 20 cases having been cleared at this stage in the previous reporting period in comparison to 58 cases in this reporting period. The increase in casework was also matched with an increase in the percentage of 'comebacks', i.e. the number of complainants who requested a review of the decision in their case. This increased from less that 1% to 22% in the reporting period, with only one of these 'comebacks' being partially upheld. A leaflet, which was designed to promote and explain the 'comeback' procedure, was introduced in March 2011 and this has undoubtedly contributed to the rise in workload in this area.

Where I find maladministration resulting in injustice, I will in many of these cases make recommendations to remedy the injustice and provide redress to the complainant. The recommendations may be that the body complained of apologises or makes a change in practice or it may also include a recommendation for financial redress that may take account of issues such as loss, distress and frustration caused to the complainant in pursuing the complaint. In 2011/12 my recommendations have not been met in four cases, and the issue of financial redress in cases involving general health service providers is currently the subject of a judicial review challenge. I am awaiting the judgement in this case.

Throughout the year my staff have met with staff from within the Health and Social Care Trusts, and the Patient and Client Council to discuss the role of my Office and to further explain the legislation under which I work in those areas which I consider to be relevant in light of the casework I have been dealing with. In these meetings my staff have focused on highlighting the differences in the legislation under which I operate in respect of issues such as who can complain to my Office and the timescale in which a complaint can be made to my Office. In relation to 'who can complain' to my Office I have highlighted that the legislation under which I operate requires the aggrieved person to make the complaint. Only in circumstances where the person aggrieved has died or is for any reason unable to act for himself may a complaint be made by his personal representative or by a member of his family or other individual suitable to represent him. I have emphasised that any question as to the suitability of an individual to act on behalf of someone else is a matter for my discretion. The reason I have highlighted this to Health and Social Care bodies is that I am aware that the health and social care complaints procedure is not so prescriptive in respect of who can complain. Therefore, in determining who can access the procedure on another individual's behalf, and ensuring the necessary data protection and confidentiality requirements are met, 'next of kin' is frequently being used by Trusts as a criterion to assess the suitability of an individual in accessing the Health and Social Care complaints procedure. Whilst I have no objection to next of kin being considered as part of an overall assessment of an individual's

suitability to access the health and social care complaints procedure, I do have concerns where this is the only criteria considered. I have seen the confusion that this approach creates for complainants, and moreover, I am concerned that a misunderstanding has been created that next of kin is a legal status bestowing rights on any person named as next of kin in relation to the affairs and decision making of another individual. I wish to ensure that information obtained is only used for the purposes for which it is obtained. Therefore, I have reminded Trusts that the primary purpose for obtaining next of kin information is so that the Trust is in possession of necessary contact details in the event of an emergency.

I have also emphasised the timescale under which a complaint can be made to my Office. I have highlighted that a complaint cannot be considered by me unless it is made within 12 months of the day on which the aggrieved person first had knowledge of the matters alleged in the complaint. I have informed Trusts that my custom and practice is to consider that the 12 month timescale applies from the date on which the Health and Social Care complaints procedure has been concluded. I have also highlighted that I do have discretion to accept a complaint made outside this timescale where I am satisfied that there are special reasons for the complainant not to have previously brought the matter to my attention.

Finally, this year my Office undertook a series of visits to healthcare units within the prisons in Northern Ireland. The purpose of these visits was to inform prison healthcare staff of my role in the investigation of complaints from prisoners about prison healthcare. The volume of casework in this area remains relatively low. Consequently, I intend to undertake further outreach with prisoners in the upcoming year.

Statistics

Caseload for 2011/12

A total of 208 complaints were received during 2011/12, 22 more than in 2010/11.

Cases brought forward from 2010/11	**89**
Written complaints received	**208**
Total Caseload for 2011/12	**297**
of which:	
Cleared at Validation Stage	**125**
Cleared at Investigation Stage (without a Report), including cases withdrawn and discontinued	**58**
Settled	**7**
Full Report or Letter of Report issued to MLA	**59**
Ongoing at 31/03/12	**48**

Written Complaints Received in 2011/12 by Authority Type

Health & Social Care Boards*	**4**
Health & Social Care Trusts	**151**
Other Health & Social Care Bodies	**53**

*My Office continued to deal with cases which had arisen prior to the introduction of the new HSC complaints procedure in 2009.

Written Complaints Received in 2011/12 by Complaint Subject

Health Service Provider	**102**
Hospital	**61**
Ambulance	**8**
Prison Healthcare	**7**
Other	**30**

Recommendations in Reported and Settled Cases

Case No	Body	Subject of Complaint	Recommendation
200701343	Southern Health & Social Care Trust	Social Services - Children	Written apology, payment of £1,000 & review of process.
200900058	Belfast Health & Social Care Trust	Hospital – Clinical Treatment & Care	Written apology & payment of £30,000.
200900068	Southern Health & Social Care Trust	Social Services – Elderly Care Services	Written apology & payment of £1,500.
200900087	Belfast Health & Social Care Trust	Social Services – Elderly Care Services & Complaints Handling	Written apology & payment of £1,500.
200900249	South Eastern Health & Social Care Trust	GP – Clinical Treatment & Care	Written apology.
200900464	Health Service Provider (GP)	GP – Clinical Treatment & Care, Complaints Handling.	Written apology & payment of £10,000.
200900489	Independent HSC Provider – Private Nursing Home	Social Services – Elderly Care Services	Written apology, payment of £1,000 & review of process.
200900666	Belfast Health & Social Care Trust	Hospital – Clinical Treatment & Care	Written apology.
200900705	Northern Health & Social Care Trust	Hospital – Clinical Treatment & Care	Written apology, payment of £250 & review of process.
200900752	Southern Health & Social Care Trust	Social Services - Children	Written apology & payment of £2,500.
200900858	Health Service Provider (GP)	GP – Clinical Treatment & Care	Written apology & payment of £5,000.
200900998	Health Service Provider (GP)	GP – Clinical Treatment & Care	Written apology.
201000013	South Eastern Health & Social Care Trust	Social Services – Complaints Handling & Administration	Written apology.
201000039	Health Service Provider (GP)	GP – Complaints Handling & Administration	Written apology, payment of £150 & review of process.
201000071	Regional Health & Social Care Board	Policy & Procedure	Written apology.
201000236	Belfast Health & Social Care Trust	Hospital – Complaints Handling & Administration	Written apology & payment of £5,000.
201000288	Health Service Provider (GP)	GP – Admission, Discharge & Transfer Procedures	Written apology & review of process.
201000326	Northern Health & Social Care Trust	Social Services - Children	Written apology.

Case No	Body	Subject of Complaint	Recommendation
201000345	Health Service Provider (GP)	GP – Complaints Handling & Administration	Written apology & review of process.
201000725	NI Ambulance Service Trust	Clinical Treatment & Care, Complaints Handling	Written apology & review of process.
201000833	Western Health & Social Care Trust	Social Services – Continuing Care	Written apology & payment of £250.
201000843	Belfast Health & Social Care Trust	Hospital – Admissions, Delay, Cancelation, Waiting Lists	Payment of £300.
201000880	Southern Health & Social Care Trust	Hospital – Clinical Treatment & Care, Complaints Handling	Written apology.
201000886	South Eastern Health & Social Care Trust	Hospital – Clinical Treatment & Care	Written apology & payment of £500.
201000933	NI Ambulance Service Trust	Clinical Treatment & Care, Complaints Handling	Written apology, payment of £500 & review of process.
201000940	South Eastern Health & Social Care Trust (Prison Healthcare)	Prison Healthcare – Clinical Treatment & Care, Complaints Handling	Review of process.
201000945	Southern Health & Social Care Trust	Social Services – Complaints Handling & Administration	Written apology & review of process.
201001344	Western Health & Social Care Trust	Hospital – Clinical Treatment & Care	Written apology & payment of £500.
201100057	Western Health & Social Care Trust	Social Services – Complaints Handling & Administration	Written apology & payment of £500.
201100083	Southern Health & Social Care Trust	Social Services - Adoption	Written apology, payment of £3,000 & review of process.
201100104	Belfast Health & Social Care Trust	Social Services – Elderly Care Services	Written apology.
201100126	Health Service Provider (GP)	GP – Policy & Procedure	Action taken by body.
201100290	Regional Health & Social Care Board	GP – Complaints Handling & Administration	Written apology & payment of £250.
201100310	Health Service Provider (GP)	GP - Referrals	Written apology & payment of £250.
201100340	Health Service Provider (GDP)	GDP – Dental Treatment & Care	Action taken by body.
201100341	Regional Health & Social Care Board	Clinical Treatment & Care	Action taken by body.
201100446	NI Ambulance Service Trust	Staff Attitude, Dignity & Confidentiality	Action taken by body.
201100547	Southern Health & Social Care Trust	Hospital – Complaints Handling & Administration	Written apology.
201100684	Belfast Health & Social Care Trust	Health Visiting – Policy & Procedure	Action taken by body.
201100728	Belfast Health & Social Care Trust	Hospital – Clinical Treatment & Care	Action taken by body.

Analysis of Written Complaints Received in 2011/12

	Brought forward from 2010/11	Received	Cleared at Validation Stage	Settled	Cleared at Investigation Stage	Report Issued Complaint Upheld/ Partially Upheld	Report Issued Complaint Not Upheld	Ongoing at 31/03/12
Health & Social Care Boards	1	4	1	1	0	2	0	1
Health & Social Care Trusts	68	151	81	4	46	24	23	41
Other Health & Social Care Bodies	20	53	43	2	12	7	3	6
TOTAL	**89**	**208**	**125**	**7**	**58**	**33**	**26**	**48**

Analysis of Written Complaints Against Health & Social Care Boards

	Brought forward from 2010/11	Received	Cleared at Validation Stage	Settled	Cleared at Investigation Stage	Report Issued Complaint Upheld/ Partially Upheld	Report Issued Complaint Not Upheld	Ongoing at 31/03/12
Regional Health & Social Care Board	1	4	1	1	0	2	0	1
TOTAL	**1**	**4**	**1**	**1**	**0**	**2**	**0**	**1**

Analysis of Written Complaints Against Health & Social Care Trusts

	Brought forward from 2010/11	Received	Cleared at Validation Stage	Settled	Cleared at Investigation Stage	Report Issued Complaint Upheld/ Partially Upheld	Report Issued Complaint Not Upheld	Ongoing at 31/03/12
Belfast Health & Social Care Trust	19	46	24	2	16	6	6	11
Northern Health & Social Care Trust	12	12	6	0	3	2	6	7
South Eastern Health & Social Care Trust	16	24	14	0	4	4	5	13
South Eastern Health & Social Care Trust (Prison Healthcare)	2	8	7	0	1	1	1	0
Southern Health & Social Care Trust	8	22	9	1	8	6	2	4
Western Health & Social Care Trust	8	31	17	0	11	3	2	6
NI Ambulance Service Trust	3	8	4	1	3	2	1	0
TOTAL	**68**	**151**	**81**	**4**	**46**	**24**	**23**	**41**

Analysis of Written Complaints Against Other Health and Social Care Bodies

	Brought forward from 2010/11	Received	Cleared at Validation Stage	Settled	Cleared at Investigation Stage	Report Issued Complaint Upheld/ Partially Upheld	Report Issued Complaint Not Upheld	Ongoing at 31/03/12
Health Service Provider (GDP)	3	9	7	1	2	0	0	2
Health Service Providers (GP)	10	32	25	1	4	6	3	3
Health Service Providers (Optometrists)	0	1	1	0	0	0	0	0
Health Service Providers (Pharmacists)	0	1	1	0	0	0	0	0
Independent HSC Providers	0	1	1	0	0	0	0	0
Independent HSC Providers (Out of Hours GP Services)	1	2	1	0	2	0	0	0
Independent HSC Providers (Private Nursing Home)	3	3	3	0	2	1	0	0
Patient & Client Council	0	1	1	0	0	0	0	0
Guardian Ad Litem Agency	1	0	1	0	0	0	0	0
Regulation & Quality Improvement Authority	1	3	2	0	1	0	0	1
NI Social Care Council	1	0	0	0	1	0	0	0
TOTAL	**20**	**53**	**43**	**2**	**12**	**7**	**3**	**6**

Appendix A

Selected Case Summaries

Assembly Ombudsman – Selected Summaries of Investigations

Department of Education – Education and Training Inspectorate

Action taken in relation to an inspection of education and training provision

The complainant in this case was the managing director of company contracted by the Department for Employment and Learning (DEL) to provide vocational training programmes. He complained about the actions of the Education and Training Inspectorate (ETI) in relation to an inspection it undertook in June 2009 of his company's education and training provision. The ETI had assessed that provision as unsatisfactory.

The complainant told me that the ETI had failed to conduct a fair inspection; that it had not given his company the opportunity to comment on the factual accuracy of its draft inspection report before communicating its proposed findings to DEL; that the ETI had no procedure for appealing against the findings of the inspection; that the ETI had failed to address thoroughly the representations his company made to it through the ETI formal complaints procedure; and that the ETI had failed to communicate its complaints procedure accurately.

I found evidence of a number of instances of maladministration on the part of the ETI, the most serious of which was the premature destruction of the contemporaneous evidence on which its assessment of the quality of the education and training provision was based. I also found that the ETI had failed to keep proper records of significant inspection-related meetings and decisions, and that it had failed to provide the complainant with clear and complete information about how to complain about the inspection. In addition, I criticised the ETI for the inadequate and inappropriate manner in which it had handled the complainant's formal complaint about the inspection, which I considered was a direct consequence of it having disposed of all contemporaneous supporting inspection documentation. I also concluded that there had been maladministration in relation to how the ETI signposted members of the public to my Office, although I was satisfied that the complainant did not sustain an injustice as a consequence of that failing. I found no evidence of maladministration by the ETI in relation to the remaining elements of the complaint, namely, the ETI's communication of the inspection findings to DEL and the absence of a specific procedure to appeal against the outcome of an inspection.

I recommended that the ETI apologised to the complainant for the failings. I also recommended that it make changes to the way in which it communicates its complaints procedure. Additionally, since I had concluded that the premature destruction of all contemporaneous supporting documentation for the ETI's evaluation of the education and training provision meant that the evaluation could not be relied upon, I recommended that the ETI did not publish the associated inspection report. The Permanent Secretary of the Department of Education accepted my recommendations. **(201000059)**

Department of the Environment

Employment Issues – Managing Attendance Policy

In this case, the complainant believed that he had suffered an injustice as a result of maladministration by the Department of the Environment (DOE) relating to the application of the Managing Attendance Policy and his receipt of a Final Written Warning. Having considered the evidence in this case, I was satisfied that the policy for managing attendance is an important tool in managing staff absence, and it is not designed to penalise employees. However, I found that, in this case, the policy was applied in an unsatisfactory and unfair manner. It is unusual for me to challenge a discretionary decision; however the evidence clearly established that the decision was attended by maladministration. I did not consider that the DOE

took all relevant factors into account when deciding to issue the complainant with a Final Written Warning, because there was no consideration of the hazardous nature of his job. Furthermore I was not satisfied that the Grade Manager provided a sufficient explanation of her deliberations to indicate why, what she considered to be, his previous poor attendance record was considered to be more significant than the fact that his absence was due to an industrial accident that occurred while he was undertaking his role as a driving examiner. Consequently, I considered the decision to issue the complainant with a Final Written Warning to have been taken with maladministration, and I upheld the complaint.

In cases where I find maladministration, my objective is to try to put the aggrieved person in the position they would have been in had the maladministration not occurred in the first place. Therefore, I recommended that the DOE revisit the decision to issue a Final Written Warning, taking into account all relevant factors. I also recommended that the Permanent Secretary issue the complainant with an apology for the poor administrative practice that I identified in this complaint. The Permanent Secretary accepted my recommendations. **(200900218)**

Department of the Environment - Planning and Local Government Group

Handling of planning application for apartments

The complainant alleged inefficient handling of his planning application for the retention of a garage with upper floor studio, WC, store, external stairs and decking area for which planning permission had been refused. The complainant also said that, due to the inefficiency of the Planning and Local Government Group (PLGG), not only did he have the expense of referring the matter to the Planning Appeals Commission (PAC), but there was also a potential loss of income due to the delay in getting the matter resolved.

My investigation revealed no evidence of maladministration in the processing of the application, nor did I uphold the complainant's allegation of unfairness and bias or prejudice on the part of PLGG. However, in refusing planning permission for the proposed development, PLGG identified three reasons for refusal. The complainant submitted an appeal to the PAC and, in preparing its Statement of Case for the PAC, PLGG withdrew one of the reasons for refusal. Contrary to procedures, the complainant was not informed of this fact prior to the submission of his Statement of Case to the PAC, which I found to constitute maladministration. However, even if PLGG had made the complainant aware of its decision to withdraw one reason for refusal, there remained two further reasons for refusal, which PLGG believed could be sustained. In order to raise all aspects of his dissatisfaction with the decision to refuse planning permission and challenge the remaining reasons for refusal, I concluded that the complainant would still have had to submit an appeal. In my view, the decision to submit an appeal and engage a professional consultant was entirely a matter for the complainant to decide and, in the circumstances, was clearly not nugatory expenditure. I also found that, although the appeal was lodged in June 2009, it was just over one year later, in July 2010, when the PAC made its decision. During this time the case was being dealt with by the PAC, and I could not hold PLGG to be responsible for any delay during this period, nor could PLGG be considered responsible for any perceived loss of income.

For failing to inform the complainant prior to the submission of his Statement of Case that one of the reasons for refusal had been withdrawn, I recommended that the Deputy Secretary of the Department of the Environment should issue an apology to the complainant together with a payment of £1,000 in recognition of the confusion and annoyance he experienced due to this failure. I am pleased to record that my recommendations were accepted. **(201000822)**

Department for Social Development – Child Maintenance Enforcement Division

Child Maintenance

In this case, the complainant was aggrieved about the handling by Child Maintenance Enforcement Division (CMED) of his child maintenance liability, following his completion of a maintenance enquiry form in respect of his two children.

My investigation found significant instances of maladministration on the part of CMED, with regard to its handling of this case. In particular, I found that CMED's decision to impose a Deduction from Earnings Order on the complainant was premature; that it failed to provide him with full details of the amount of child maintenance arrears and how they were calculated; that it delayed in handling his request for an adjustment to his child maintenance liability; that it failed to notify him of a home visit; and that it breached confidentiality.

In terms of injustice, it was evident to me that the complainant experienced considerable frustration, inconvenience, and distress over a protracted period of time. By way of redress, I concluded that he should receive a letter of apology from the Acting head of CMED, together with a payment of £1,000. I am pleased to record that my recommendations were accepted. **(200900802)**

Northern Ireland Environment Agency

Handling of complaint about illegal dumping of domestic waste

The complainant in this case was aggrieved about the actions of the Northern Ireland Environment Agency (NIEA) in response to his concerns about the alleged illegal dumping of waste at the property next door to his home. He informed me that he first brought the matter to the attention of Belfast City Council. The Council reported the alleged illegal dumping to NIEA in February 2009.

Over the following months, the complainant made numerous written enquiries to NIEA regarding the action it was taking to address the problem. Not all his correspondence was answered. In August 2009, he was advised that NIEA had commenced "corrective action" but was given no further information about what that involved. In October 2009, he was informed that NIEA's actions were constrained by "a lack of staff" and "the legal process". At that same time, NIEA declined an offer he had made to provide details of those he believed to be responsible for the illegal dumping. In February 2010, NIEA advised the complainant that having "exhausted all powers available to it", it could take no further action on the matter. Subsequently, in October 2010, he was advised that NIEA had decided that pursuing legal proceedings in relation to the dumping problem would not have been "proportionate".

I upheld this complaint in part. I found no evidence of maladministration in NIEA's discretionary decision not to pursue legal action against the owner of the site where the dumping has occurred, and I am satisfied that the action NIEA took to address the complainant's concerns was proportionate in the circumstances. However, I concluded that there were some instances of maladministration by NIEA in the manner in which it responded to his concerns about the dumping. These included NIEA's failure to provide complete and accurate responses to some of his enquiries, and to deal appropriately with some of his correspondence.

By way of redress for the frustration and distress experienced by the complainant as a result of NIEA's failings, I recommended that the Chief Executive should write a letter of apology to him, and that NIEA make a payment to him of £500. The Chief Executive accepted the findings of my investigation and my recommended remedy. **(201000840)**

Planning Service

Handling of planning application

The complainant represented an association, which was set up to respond to planning proposals that

affected the local area. He complained on behalf of the association that Planning Service (PS) had processed a particular planning application - for the creation of a residential development in place of an 18-hole golf course - in a way that was in breach of its own policies and procedures.

A total of 63 separate issues of complaint were brought to my attention. Having reflected on the issues raised, I decided to focus my investigation on the following allegations:

- PS had failed to take account of planning policy and opinion that opposed the granting of planning permission;
- PS had accepted various claims made in support of the application without appropriate evaluation of those claims; and
- A senior planning official had exerted inappropriate influence in the planning process.

I obtained a substantial amount of documentation from both the complainant and PS. However, the most significant piece of information in this case was the fact that PS had not issued a formal Decision Notice for the planning application in question. In fact, before PS could reach a final decision, the planning application had actually been withdrawn by the applicant.

My investigation did not find any evidence of maladministration on the part of PS in this case. I would add that my findings were limited by the 'withdrawal' status of the planning application which, in essence, meant that the end of the decision-making process had not been reached by PS. **(201000684)**

Handling of planning application

The complainants lived beside a site for which a planning application had been submitted to build tourist accommodation (self catering apartments). While Planning Service (PS) was considering the application, the complainants discovered that the plans included proposals for what they believed to be permanent residential accommodation. They claimed that this was in contravention of Planning Policy Statement 21 – Sustainable Development in the Countryside. I am aware that PPS 21 permits accommodation in respect of tourism development, but the context is one of non-residential development. The accommodation in question consisted of a large bedroom (with ensuite) and a kitchen.

The complainants raised their concerns with PS who investigated the matter and found that the applicant had indeed intended to include a permanent residential unit (for staff) as part of the application. The complainants alleged that PS had failed to recognise this fact and, in ignorance, had been preparing to recommend the application for approval to the local council. The complaint also included claims that PS had failed to respond to a letter; failed to meet publicised timescales for responding to correspondence; failed to take account of previous refusal decisions in respect of previous planning applications for the same area; and failed to require a new point of access onto the public road, which had been proposed by the applicant, to be the publicised address of the site.

As a result of my investigations, I was satisfied that, before the complainants had approached PS with their concerns, PS had applied a reasonable interpretation to the proposed accommodation in question, concluding that it was not sufficient to provide a reasonable standard of living as a permanent place of residence, and that it was not a separate residential unit. Essentially, I found that the complainants and PS did not agree on whether the accommodation in question could be described as permanent residential accommodation.

I was satisfied that PS had acted promptly by making enquiries of the applicant as soon as the alternative interpretation had been raised by the complainants. As a result of those enquiries, I noted that PS had discovered that the complainants had actually been correct, and that the applicant had intended the accommodation in question to be a permanent residential unit. I noted that PS had then acted to resolve this issue and, subsequently, the applicant had submitted corrective plans. I noted that the planning application was finally approved some months later.

In relation to the other aspects of complaint, I found that the missing reply had been provided, with an apology, within a period of four weeks

from the date of receipt of the original letter, subsequent to the discrepancy being highlighted by the complainants. I also found that, where PS had failed to meet its published target for responding to written correspondence, it had made a written apology to acknowledge this to the complainants. I considered this to be sufficient redress in the circumstances. My investigation found that PS had taken account of previous planning decisions and, I was satisfied that the address provided by the planning applicant was an appropriate address for the site. I did not find maladministration in any aspects of the complaint. **(201000508)**

Planning permission for apartments

This complaint was against the Planning Service (PS). The main issues concerned the granting of planning permission for the demolition of 2 pairs of semi-detached properties and the construction of 1 block of 9 apartments and 1 pair of semi-detached houses at Malone Road, Belfast. The complainant alleged that, in processing the planning application, PS had breached specific policy / guidance and had failed to consider his objections. My investigation revealed that the application site, which was the subject of the complaint, was separated from the complainant's property by another site at Malone Road, which had previously been granted planning permission for the erection of 18 apartments. The distance of the development, which was the subject of the complaint, from the complainant's property was a significant factor in my consideration of the complaint. In the circumstances, I did not conclude that any major adverse impact, such as overlooking, would result. I concluded that the complainant's objections were recorded, and those relevant to the consideration process were considered by the PS prior to the granting of planning permission. Also, I found no evidence of PS having breached relevant policy / guidance in the processing of the application in question.

I did not uphold the main elements of the complaint and I found no reason to challenge the final decision to grant planning permission for the development. **(201000111)**

Unsatisfactory enforcement response

The complainant was an elderly lady who suffered from ill health and lived alone in a small mid terrace house. Upon returning home from a period in hospital, the complainant discovered that her neighbour had built a rear first floor extension, the eaves, guttering and roof tiles of which encroached on to the complainant's property. The complainant raised the matter of the encroachment with Planning Service (PS), through her local MLA, and it transpired that her neighbour had not obtained planning permission for the extension.

During the course of a number of site visits and meetings with PS officials, the complainant endeavoured to have the issue of the unwanted overhang addressed as a matter of enforcement. However, the matter concluded some months later with retrospective planning approval being granted for the encroaching extension and the complainant being left in the same position she was in when she had originally discovered the unauthorised development. The complainant was unhappy with the outcome and raised a complaint with me.

My investigation found that when the complainant approached PS for help regarding the unauthorised development, the information and advice she received was inadequate regarding what she could expect from its enforcement service. I also found the administration of the retrospective planning application to be flawed. I found that while PS sought to regularise the breach of planning control by requiring a late planning application to be submitted, it failed to act to resolve the complaint raised concerning the encroachment of the extension. I found this to be anomalous given the existence of planning guidance that outlines the need to prevent "unneighbourliness" and deter unwelcome incursions into neighbouring property.

I was further concerned to find that the planning permission that was eventually granted was not in conformity with the 'as built' extension. In particular, I noted that the extension differed markedly from the plans submitted by the applicant.

I considered that the above failings each constituted maladministration. In recognition of the delay, frustration, time and trouble experienced by the complainant who I viewed as a vulnerable member of the community by reason of age and ill health, I recommended the following:

- A written apology from the Chief Executive of PS to the complainant;
- A payment of £4,000; and
- The production of a public information leaflet to explain the role of the PS in the enforcement of 'unneighbourly' extensions.

The Chief Executive accepted my recommendations. **(200800835)**

Rivers Agency

Action taken in response to report of flooding

The complainant in this case owns land on the upstream side of a road situated within a rural area. He complained to me that in 2004, shortly after Roads Service had undertaken alteration work to the road drainage system at that location, his land became subject to water-logging. He reported his concerns to Roads Service in April 2004. Roads Service began to liaise with Rivers Agency in order to resolve his concerns. Over the following period, Rivers Agency indicated on a number of occasions that it was to take action regarding the condition of the watercourse downstream from the complainant's land. In August 2008, Rivers Agency advised him that it considered the flooding problem was being caused by the road drainage works that Roads Service had undertaken in 2004. Although Rivers Agency again agreed in October 2008 to pursue the condition of the downstream watercourse, it decided subsequently not to do so. In August 2009, Rivers Agency informed the complainant that the flooding problem was a matter for Roads Service to address. The problem remains unresolved.

The complainant informed me about Rivers Agency's decision not to pursue the condition of the downstream watercourse, despite having previously undertaken to do so. He also contended that Rivers Agency has delayed in taking action to have the water-logging problem satisfactorily resolved.

My investigation found that during the period April 2004 to October 2008, Rivers Agency did indicate on a number of occasions that it was to take action regarding the condition of the downstream watercourse. However, I also found that its subsequent decision not to pursue that particular course of action was attended by maladministration, primarily because the decision had not been informed by all relevant considerations. I also found a number of instances of maladministration in some aspects of Rivers Agency's handling of the complainant's concerns about the water-logging problem. These included delay in taking action, and the failure to keep proper records of meetings and site visits. In light of the failings I identified, I recommended that the Chief Executive of the Rivers Agency write a letter of apology to the complainant and that Rivers Agency make a payment of £3,000 to him. I also recommended that Rivers Agency review its decision not to pursue the condition of the downstream watercourse. The Chief Executive accepted both the findings and recommendations made as part of my investigation. **(201000113)**

Roads Service

Action taken in response to report of flooding

The complainant in this case owns land on the upstream side of the Clontonacally Road, Carryduff, Belfast. He complained to me that in 2004, shortly after Roads Service had undertaken alteration work to the road drainage system at that location, his land became subject to water-logging. He reported his concerns to Roads Service in April 2004. Roads Service, being of the view that the problem was due to the unsatisfactory condition of the watercourse that ran downstream from the Clontonacally Road, began to liaise with Rivers Agency in order to resolve his concerns. In January 2010, Roads Service informed him that it had taken all reasonable and practical steps to address the problem. However, the water-logging problem remained unresolved.

The complainant informed me that the road drainage alteration works undertaken by Roads Service in 2004 have caused the water-logging of his land. He also contended that Roads Service had delayed in addressing his concerns and that it

failed to take the action necessary to have the problem satisfactorily resolved.

Having investigated this complaint, I found no conclusive evidence that the works completed by Roads Service in 2004 had directly caused the drainage failure that is now evident at the complainant's land and I did not therefore uphold that element of his complaint. However, I found evidence of a number of instances of maladministration in aspects of Roads Service's handling of his concerns. I concluded that Roads Service did not always take timely action to expedite the addressing of those concerns, and that it failed on a number of occasions to deal appropriately with representations that were made to it by the complainant. In addition, I found it necessary to criticise Roads Service for failing to keep proper records of all meetings, discussions, and site visits, relating to its response to the complainant's concerns.

In light of these failings, I recommended that the Chief Executive of Roads Service write a letter of apology to the complainant, and that Roads Service make a payment of £1,000 to him. The Chief Executive accepted the findings and recommendations made in my investigation report.
(200900877)

Ulster Scots Agency

Grant Funding

The complainant in this case was acting on behalf of an Ulster Scots group which received grant funding from the Ulster Scots Agency (the Agency). The complainant was aggrieved about a number of matters including delays in receiving grant payments from the Agency, a shortfall in funding, the withdrawal of funding in 2009, and the Agency's failure to attend two meetings with the group concerned.

Having completed an investigation of the various matters raised, I did not uphold the main elements of this complaint.

My investigation established that, based on audit issues, a number of groups and individuals who had received funding from the Agency were deemed, in 2009, as being ineligible to apply for further funding under the Financial Assistance Scheme until such time as that Scheme had been revised and approved by the North South Ministerial Council in July 2009. In these circumstances, I did not uphold that element of the complaint that funding to the group concerned had been withdrawn by the Agency in 2009.

However, my investigation established that the Agency failed to meet its target timescale on two occasions in issuing grant payments to the group. I considered these failures as constituting evidence of maladministration by the Agency. Also, my investigation identified several instances of unsatisfactory administration by the Agency in relation to its record keeping and its failure to respond to a letter from the complainant.

By way of redress, I recommended that the Interim Chief Executive of the Agency should issue a written apology to the complainant, with the apology extending to the group he represented. I am pleased to record that the Interim Chief Executive accepted my recommendations.
(201000250)

Commissioner for Complaints – Selected Summaries of Investigations

Arts Council of Northern Ireland

Grant Funding

The complainant in this case was acting on behalf of an Ulster Scots group which received grant funding from the Arts Council of Northern Ireland (ACNI). The complainant was aggrieved about a number of matters including the failure of ACNI to provide employment guidance; that he was not involved in training in governance and financial management that ACNI had delivered to the group; and about the financial effect of changes to the group's status.

The complainant informed me that the group received funding from ACNI to enable it to employ someone for a six-month period. However, the complainant was dissatisfied that ACNI failed to provide the group with satisfactory employment guidance. My investigation ascertained that the group had previous experience of employing staff, and that it did not seek detailed employment advice from ACNI. In these circumstances, I considered that ACNI was reasonably entitled to believe that the group had sufficient knowledge and experience in matters relating to the short-term employment of staff.

In relation to the training that ACNI delivered to the group, my investigation established that this was aimed at, and intended for, the group's Board members, and that the complainant was not a Board member of the organisation concerned.

The complainant believed that as the group had changed its status from an association to a limited company, this had resulted in an application it made to ACNI for funding in respect of the 2010/11 financial year being deemed ineligible. However, my investigation established that the determining factor in ACNI reaching that decision was the fact that, rather than changing its name and status, the group had been wound up and a new organisation formed in its place. In this regard, ACNI's guidelines in relation to the relevant funding scheme state that 'organisations which have not received at least £10,000 over the last three financial years' are not eligible to apply. The 2010/11 application for funding had been made to ACNI by the newly formed organisation.

Having completed a detailed investigation of this case, I found no evidence of maladministration by ACNI in relation to any of the various matters raised in the complaint. Consequently, I did not uphold this complaint. **(201001301)**

Craigavon Borough Council

Failure to follow policy and procedures

The complainant in this case said he initiated a grievance against another employee of Craigavon Borough Council (the Council) on the basis of what he believed was an unfounded allegation made against him by the other employee in the course of a discussion. The complainant's grievance was investigated by the Council and the subsequent report of the investigation stated that there was sufficient evidence to support his claim that he had been publicly accused of malicious conduct.

The Council employee, against whom his grievance was made, subsequently appealed the findings of the Council's investigation. That appeal was upheld on the basis of inappropriate process, as a result of which the conclusions and recommendations in the investigation report prepared by the Council were set aside.

In notifying him of the outcome, the Council stated that the appeal was conducted under the fourth and final stage of its former grievance policy and it considered the matter to be closed. The complainant said he had been humiliated and betrayed by the Council because of its apparent failure to follow its policy and appropriate procedures in this case.

Having completed an investigation, I identified several instances of maladministration by the

Council including 'process deficiencies' which had flawed the grievance procedure in this case; a failure by the Council to record explicitly the method by which it would investigate and deal with the grievance; and confusion on the part of the Council as to the stage of the grievance procedure in which the appeal in this case was heard. In these circumstances, I fully upheld this complaint.

By way of redress, I recommended that the Chief Executive of the Council should issue a written apology to the complainant, and that the Council should make a payment of £150 to him in recognition of the time taken to properly address his complaint. I was pleased to record that the Chief Executive accepted my recommendations.

Also, I was pleased to note and welcomed the fact that the Council had introduced and implemented a revised grievance policy with effect from April 2011. I was also pleased to note, and reassured by, the range of measures that the Council had given a commitment to introduce in order to ensure that there would be no recurrence of its failures in this case. **(201100543)**

North Down Borough Council

Disposal of garden waste

I received a complaint from a landscape gardener who believed that North Down Borough Council (the Council) was wrong in charging him for the disposal of garden waste at the Council's Recycling Centre. The complainant told me that he had helped out a friend by delivering garden waste to the Recycling Centre. On another occasion he had disposed of garden waste from his own property. He was charged on both occasions for the disposal of this garden waste. He complained to the Council who eventually refunded the charges. However, he remained unhappy with the handling of his original complaint, the subsequent delays, and the lack of apology from the Council following the refund of what he considered to be unwarranted charges.

My investigation identified maladministration in the Council's actions. These included delays in its handling of the complaint, and the lack of apology or explanation given following the refund of the charges he had incurred. I recommended that the Chief Executive should personally apologise for the inconvenience caused by the unacceptable delays in the administration of the complaints process, and for the incorrect charges levied in this case. I also recommended that the Council make a payment of £250, in recognition of the inconvenience caused to the complainant in pursuing his complaint.

In the course of my investigation, I also indentified that the Council had no legislative authority to charge for the deposit of household waste, irrespective of who delivers the waste to the Recycling Centre. I noted with concern that the Council had been charging commercial users, such as the complainant, to dispose of household waste when they had no authority to do so. The decision to charge for the deposit of waste must be based on the nature of the waste, and the Council should make decisions on whether to accept the waste or charge for it on a case-by-case basis, and not by reference to any blanket policy or the particular business being carried out by the person delivering the waste.

I recommended that the Council should make arrangements to advise members of the public that no charge would be levied by the Council for the disposal of 'household' waste. I also recommended that the Council should offer refunds to those users of the recycling facility who have been incorrectly charged for the disposal of household waste at a Council facility. My recommendations were accepted. **(200801252)**

Oaklee Homes Group

Service charges

I received a complaint from a lady who was aggrieved that the weekly support charge she paid to Oaklee Homes Group (Oaklee) did not reduce in accordance with its provision of reduced support service to her. In particular, the complainant explicitly requested that I addressed whether she is entitled to a refund of support charges, and whether a particular paragraph in Oaklee's policy

on 'Support Charges for Sheltered Schemes' applied to her. The complainant also asked that I investigate issues surrounding how Oaklee's financial management of accounts had an impact on her potential entitlement to a refund for support charges, and how Oaklee had responded to her complaint.

During my investigation I found maladministration by Oaklee. In particular, Oaklee did not reduce the support charge paid by the complainant when her support service reduced in the years 2001 and 2002; it did not inform her in writing four weeks in advance, as stipulated in her Tenancy Agreement, of a reduction in the Scheme Co-Ordinator's weekly working hours; and it also failed to provide the complainant with clear and adequate responses at stages 1 and 2 of its complaints process. I also identified injustice to the complainant as a result of her support charge not being reduced when her support service reduced in the years 2001 and 2002 and, therefore, I have recommended Oaklee offer a comprehensive apology, together with a payment of £500.

I am pleased to note that Oaklee's Chief Executive (CE) accepted my recommendations and, as a result of my investigation and findings, intends to introduce additional amendments to policy to provide tenants with a clearer understanding of Oaklee's service and support charges. I also welcome and commend the CE for indicating his intention to make a suitable payment to the other residents of the same scheme who were similarly affected during the period May 2001 - April 2003. **(201100122)**

Commissioner for Complaints – Selected Summaries of Health and Social Care Investigations

Belfast Health and Social Care Trust

Failure to properly investigate

This complaint relates to the Belfast Health and Social Care Trust's (the Trust) investigation of a serious adverse incident that occurred whilst the complainant's daughter was undergoing routine surgery.

I found that the Trust's investigation had serious deficiencies in addition to a number already identified by the Trust's own review. I was not satisfied that external reviews commissioned by the Trust were sufficiently independent. I considered that the Trust's handing of the governance issues of this complaint were attended by maladministration. I was satisfied, however, that the Trust has now dealt with all clinical matters raised by the complaint.

I upheld the complaint and recommended that the Trust provide the complainant with an apology and a payment of £5,000. The Trust agreed to implement my recommendations. **(201000236)**

Delay in getting an appointment

In this case the complaint was unhappy because she had to wait longer than anticipated to be reviewed by the chronic pain service. She also complained that she was overlooked for an appointment and that her medical notes were not complete.

I found no evidence that she was overlooked for an appointment or that her medical notes were incomplete. However, the Trust accepted that the complainant waited a longer time for her review appointment than was originally anticipated by her

consultant. The Trust stated that whilst other patients were also delayed it was unable to provide evidence that the complainants delay was due, in its entirety, to patient demand. I considered this avoidable delay to constitute maladministration and upheld this aspect of the complaint. I recommended that the Trust provided the complainant with a payment of £300 in recognition of the injustice she experienced. The Trust agreed to implement my recommendations. **(201000843)**

Treatment Received in Nursing Home

This case relates to an elderly lady who was resident in a nursing home. In the months prior to her admission, she had been suffering from a cough and was suffering from dementia. During her stay in the home, her cough persisted and her condition deteriorated. Sadly, following a fall and a further deterioration in her condition, the lady passed away in the Mater Hospital.

The deceased lady's son complained to the Belfast Health and Social Care Trust (the Trust) about the treatment his mother received during her stay at the Home. He was unhappy about the clinical and nursing treatment his mother received, as well as the activities provided for her by the Home. It was his view that overall, the Home had failed to account for his mother's individual preferences when caring for her.

The Trust, in conjunction with the Home, investigated the complaint under the Health and Social Care (HSC) Complaints Procedure. The Trust upheld some elements of the complaint and an apology was offered to him. However, the complainant remained unhappy with the response he had received from the Trust and therefore requested that my Office investigate his complaint.

In the course of his investigation, I requested background documentation from the Trust, as well as copies of the deceased lady's GP and Care Home records. In respect of several clinical elements of the complaint, I also requested medical advice from an Independent Professional Advisor (IPA). Having taken all of this information into consideration, I did not uphold the majority of the issues identified in the complaint. It was my judgement that in respect of the majority of the issues raised by the complainant, the Trust did in fact thoroughly investigate the matters identified, and as a result the Home introduced a number of remedial measures and issued an apology for the failures which it acknowledged.

However, I did identify two areas of clinical care provided by the Home which were not of an appropriate standard and I was concerned that these failures were not identified during the Trust's investigation. Accordingly, I did uphold the complaint in two regards, namely the adequacy of the nursing assessment completed in evaluating the irritating condition presenting in his mother's legs, which was described by her son as 'itchy legs', and also the standard of dental care provided by the home. Specifically, I indicated that I had identified concerns regarding the thoroughness of the Trust's investigation in respect of both these issues.

In respect of those issues within the complaint, which I had upheld, and the related areas of concern I had identified during my investigation, I recommended that the Trust issue an apology to the complainant. The Trust agreed to implement my recommendations. **(201100104)**

Northern Health & Social Care Trust

Care and treatment at A&E

In this case, I was asked to investigate a complaint against the Northern Health and Social Care Trust (the Trust) relating to the care and treatment received by the complainant when attending the Emergency Department (ED) in the Mid Ulster Hospital with an ankle injury.

The complainant was initially treated for a possible (or 'hairline') fracture, and ten days later for a severe sprain. No definite acute fracture was identified on the x-rays performed by either of the Emergency Nurse Practitioners (ENPs) who treated the complainant on each of her attendances, or by the radiologist who subsequently reported on the x-rays.

However when the complainant was later referred by her GP to the Altnagelvin Hospital with persistent pain and x-rayed there, a spiral or

oblique fracture of the bone on the outside of the left ankle (distal left fibula) was diagnosed. She was subsequently followed up in the Altnagelvin Hospital's Fracture Clinic, where her foot was placed in a cast.

The complainant submitted a complaint to the Trust, however, she was not satisfied with the response which she received, and she therefore submitted her complaint to my Office. Details of the complaint were sent to the Chief Executive of the Trust. I requested all of the documentation relating to the handling of the complaint, and any relevant comments or observations on the points which had been raised by the complainant. To assist in my consideration of this case, I also had the benefit of detailed advice from five Independent Professional Advisors (IPAs).

I carefully examined the evidence, including the advice received from my IPAs, and concluded that the complainant had suffered injustice as a result of maladministration by the Trust. The reporting radiologist failed to fully discharge her reporting responsibilities as set out in 'The Royal College of Radiologists – Standards for the Reporting and Interpretation of Imaging Investigations (2006)'. I also concluded that during the complainant's attendance at the ED on the second occasion, it would have constituted good practice for the ENP to have obtained a senior medical opinion in relation to the complainant's condition. I have also found that the ENP treating the complainant on that occasion should have arranged a further follow up appointment to monitor for clinical improvement and if judged necessary to arrange for a senior medical opinion and/or further imaging to be undertaken.

As a result of the maladministration I identified, I believe that the complainant was denied the opportunity to have her fracture diagnosed earlier, which potentially led to her suffering unnecessary pain until she attended the Altnagelvin Hospital. This also extended her recovery period. On the basis of my IPA advice, I am satisfied however that the three weeks of not being immobilised and attempting to bear her body weight on an injured foot should not have had any significant bearing on the long term outcome of the fracture. From the evidence examined by my IPAs, the complainant's recovery does not appear to have been adversely affected.

I made a number of recommendations to the Trust to ensure that the learning from this complaint is disseminated to all relevant staff within the Trust. I also recommended that the Trust provides the complainant with a full written apology and a payment of £250 in recognition of the fact that she was denied the opportunity to have her fracture identified at an earlier stage, and the resultant avoidable pain and discomfort this may have caused her. I am pleased to note that the Trust accepted my recommendations. **(200900705)**

Child Protection

The complainant in this case originally contacted the Northern Health and Social Care Trust (the Trust) with concerns relating to the safety of his young daughter. As he was unhappy with the standard of care provided by the Trust, he subsequently submitted a formal complaint. Following the Trust's investigation of the complaint, he remained dissatisfied and brought his complaint to my Office for investigation.

Having completed an investigation, which involved analysing background documentation supplied by the Trust and advice from an Independent Professional Advisor (IPA), I did not uphold every aspect of the complaint, although I did uphold a substantial part of it. It was my view that the Trust's handling of this case was not in compliance with the relevant guidelines, as well as being inconsistent with the Trust's own recommendations, in several respects. As a result, I determined that these failures undermined the reliability of the measures introduced to guarantee the child's safety. In addition, I was critical of the Trust's record keeping in several respects.

It was my conclusion that the failings indentified above constituted maladministration on the part of the Trust. As a consequence, I recommended that the Trust issue an apology to the complainant acknowledging these failings, and providing him with reassurance that the setting in which his daughter is placed will be appropriately monitored in the future. Furthermore, I recommended that the Trust produce an action plan in order to

address the outstanding work still to be completed with the child's family relating to domestic violence. However, I was satisfied that the Trust had adequately completed initial background checks in relation to those involved in this case. I concluded that the Trust had made reasonable attempts to source information as requested by the complainant in his letters of complaint. Furthermore, having reviewed the Trust records of the complainant's contact with the Out of Hours service, I was satisfied that the concerns he had raised were responded to appropriately. The Trust agreed to implement my recommendations. **(201000326)**

Care Assessment

This complainant was unhappy that the Northern Health and Social Care Trust (the Trust) had deemed his mother suitable for residential care as opposed to nursing care. In particular he stated that:

- his mother should never have been moved to the residential home as staff in her previous nursing home stated that she was not suitable for residential care and that she needed nursing care;
- his mother's Social Worker gave him an ultimatum that his mother could either be moved to the residential home or to Muckamore Abbey Hospital;
- after he complained to the Trust, his mother was reassessed twice. He stated that the results of the two reassessments were not an accurate reflection of his mothers' condition;
- his mother received poor care in the residential home. She received no stimulation and was given no assistance to eat;
- the Trust did not follow correct procedures and was in breach of the Human Rights Act in not consulting him or his mother about the move to the residential home; and
- the lack of care afforded to his mother in the residential home may have contributed to her demise.

Having completed my investigation of this complaint I was satisfied that there was no maladministration in relation to how the Trust carried out its assessments, and that the decision to place the complainant's mother into a residential home was reasonable. I did not find any evidence that this decision led to a decline in the complainant's mothers' health. I was critical that, contrary to DHSSPS guidelines, the Trust did not agree the care plan for the complainant's mother with her family, but I was satisfied that this did not have an adverse effect on the care provided to her. Therefore, I did not uphold the complaint. **(201000495)**

South Eastern Health & Social Care Trust

Treatment and care

This complaint centred on the quality of care provided to the complainant's son by Downe Residential Project (DRP) during periods of respite care. The Trust contracts with DRP, which is a registered charitable company, and pays them the full cost for respite service provided to the client. The Trust then recovers any assessed financial contributions from the client. However, as DRP is not a body within my jurisdiction, my investigation was limited to the Trust's handling of the aggrieved person's complaint, as opposed to the substance of his complaint against DRP.

From the evidence available to me, I noted that the Trust completed a review of DRP's investigation and concluded that there were several unacceptable lapses in the quality of care received by the complainant's son during periods of respite provided by DRP. I also noted that in his response to the complainant, the Trust's Chief Executive made reference to the apology issued to the complainant by DRP for these lapses in the quality of care and its willingness to work with him to restore his former confidence in the respite service. I further noted that the Trust took the view that it was not in a position to refund all payments made by the complainant to the Trust, given that the complainant's son's care, housing and support needs were funded by the Trust and met throughout the period in question by DRP.

Overall, I considered that the Trust took this complaint seriously and made a comprehensive effort to address the issues raised by the complainant. Although it was clear to me that, as a result of the events complained of, the complainant experienced a stressful situation, I found no evidence to demonstrate that he suffered an injustice as a consequence of maladministration by the Trust. Therefore, I did not uphold his complaint. **(201001210)**

South Eastern Health & Social Care Trust (Prison Healthcare)

Care and Treatment

The complainant in this case was committed to HMP Maghaberry. His medical history included a diagnosis of Post Traumatic Stress Disorder (PTSD), stemming from his experiences whilst serving in the army, and a long-standing back condition.

During his period in prison, the complainant was dissatisfied with several aspects of the medical treatment provided to him. He was unhappy with the level of psychiatric intervention provided, the administration of his medication, and what he perceived to be the failure of prison healthcare staff to provide him with a wheelchair. As a result, the complainant submitted several complaints using the Prison Healthcare Complaints Procedure. Due to his continued dissatisfaction, these complaints were eventually progressed to the South Eastern Health and Social Care Trust (the Trust) to be investigated further under the HSC Complaints Procedure.

As the complainant still remained dissatisfied, he wrote to my Office to request that I investigate his complaint. Accordingly, in the course of my investigation, I corresponded extensively with the Trust to obtain all of the background to the complaint. In addition, I obtained a copy of the complainant's GP records and requested independent medical advice in respect of the clinical elements of his complaint.

Having completed a thorough investigation of all the evidence available, I did not uphold the complaint. I determined that the clinical care provided was of an appropriate standard and furthermore, the investigation did not identify any evidence of maladministration by Prison Healthcare staff in respect of the issues raised in the complaint. **(201001304)**

Southern Health & Social Care Trust

Social Care Services

The complainant asked me to investigate her complaint about the care and treatment provided to her aunt by the Southern Health and Social Care Trust (the Trust).

The complainant's aunt was discharged from hospital in June 2007 following a lengthy stay. As a result of her weakened physical state at the time of her discharge, she was assessed by the Trust's multi-disciplinary team as being at risk and in need of 24-hour supervision. The Trust was of the view that she would be better placed in a Nursing Home environment. The complainant and her aunt were strongly opposed to this and wanted her to return to her home. To facilitate this, the Trust put together a care package, which the complainant claimed did not meet her aunt's needs, as 24-hour care was not provided by the Trust.

This investigation took a considerable length of time to complete. The delay was due in part to inadequate responses initially received from the Trust, which did not address the issues I had identified. These inadequate responses have hindered my investigation. During the course of my investigation, I expect full access to all documentation relevant to a case and I consider it a poor reflection on the body concerned if I find I have to return to it on further occasions before I am satisfied I have received all of the information I originally requested.

The complainant indicated to me that she did not agree with the recommended package of 24 hour care and had requested on numerous occasions that the Trust increase their input of service to

meet her aunt's needs. However, my investigation revealed no records of the family raising concerns about the content of the care package provided until March 2008, and no evidence to suggest the family ever disputed the level or content of the 24 hour package of care provided by the Trust. With this in mind, I also had to consider the degree to which the complainants failed to clearly raise the issues with the Trust which formed the basis of the complaint.

Having carefully examined all the evidence, I found that the failure of the Trust to properly apply procedures in relation to providing a comprehensive care package to the complainant's aunt constituted maladministration. I was of the view that the complainant and her family were not given clear instructions as to what was expected of them in order that their wish for their aunt to remain at home be implemented. Firstly, there was insufficient evidence to support the Trust's decision to recommend 24-hour care. Furthermore, in my view, the record keeping and documents in this case were in such disarray, that no reasonable informed decision could have been arrived at. There was a clear lack of documentation to evidence appropriate assessment and case planning for the complainant's aunt in terms of her care needs.

I recognise the stress that families can experience in caring for an elderly relative. Sadly, the complainant's aunt died in December 2008 and, unfortunately, as circumstances do not allow for a reassessment to determine what the outcome would have been had the identified maladministration not occurred, I could not conclude with sufficient certainty that the outcome would have been different or more positive for the family. In considering an appropriate remedy for the maladministration, I had to consider if there has been any definitive injustice to the complainant's aunt or her family. I was unable to determine if costs were incurred as a direct consequence of poor practice by the Trust given that it can not now be determined if the recommendation for 24-hour care were appropriate at that time.

However, I was satisfied that the Trust had demonstrated that it has already taken steps to learn from the case. In terms of remedy for the complaint against the Trust, I recommended that the complainant should receive an apology for the inadequate case management of her aunt's case. I also recommended that the Trust make a payment of £1,500 in recognition of the time, trouble and inconvenience these failures caused the family in pursuing their complaint, which it accepted. **(200900068)**

Withdrawal of Meal Delivery Service

I received a complaint from a lady who felt that she had sustained injustice as a result of the withdrawal of a meal delivery service previously provided to her by the Southern Health and Social Care Trust (the Trust). The complainant alleged that she had been treated differently to other residents in the Fold where she resided.

The Trust advised that when the complainant was first assessed, there were no specific criteria that had to be met in order to access Meals on Wheels services but it was identified at that time that she had difficulty preparing a meal. Their assessment did not examine potential alternative providers and therefore cooked chilled meals were provided to the complainant by the Trust. A reassessment was carried out the following year under the Trust's criteria for access to Homecare Services and Equipment, which included the criteria specifically relating to the provision of meals. The assessment identified that the complainant's meal requirements could be met by an alternative provider.

My investigation revealed that a financial assessment was conducted with the complainant and, as part of that review, no financial issues were identified. The Trust provided the complainant with information and practical support to access a range of community alternatives to statutory meal provision. She was also provided with a list of private providers, some of whom will deliver meals directly to her door.

The Trust informed me that since making the complaint, the complainant's care needs have changed and she now has additional support to assist her with morning personal care requirements. The Trust has assured me that the complainant's personal care and meal requirements will continue to be kept under regular review. In relation to other

residents within the Fold being provided with this service, I concluded that it would be inappropriate for the Trust to comment upon the services it provides to other service users as all service users have distinct and individual needs.

To conclude, I found that the Trust dealt with this case fairly and had taken account of the individual circumstances. I did not therefore investigate this matter further. **(201000500)**

Care and Treatment

This complaint related to the care and treatment provided to the complainant's husband following surgery in 2008. The complainant was also unhappy with how the Trust communicated with her as her husband's next of kin.

My investigation did not find any evidence of mal-administration in relation to the care and treatment provided to the complainant's late husband, or in how the Trust communicated with her. I did, however, find that the Trust did not deal with the initial complaint in a satisfactory manner because it failed to provide the complainant with an adequate explanation of the cause of her late husband's death.

I therefore upheld this element of the complaint. I recommended that the Trust provide the complainant with an apology and offered her an opportunity to meet with Trust representatives to clarify the events surrounding her husband's death. The Trust accepted my recommendations. **(201000880)**

Treatment and Care

This complainant had previously submitted a complaint regarding the treatment he received at Craigavon Area Hospital. Following the closure of that complaint, he wrote to my Office and requested that two additional issues be investigated:

The fact that his call bell was broken while he was being treated as an inpatient at Craigavon Area Hospital, which caused delay in staff responding to his requests for assistance; and

The waiting time he endured, and the treatment he received, at Craigavon Area Hospital prior to being admitted.

The first issue was not accepted for investigation as it had been considered during the investigation of his previous complaint. Due to a lack of evidence, it had not been possible to ascertain any causal link between call bell response times and the quality of the complainant's treatment. In addition, the reason that the call bell was inoperable was because the complainant had been situated at a bed in full view of the nurses station to provide him with closer attention. In addition, he had been provided with a hand bell as an alternative, and I considered the action taken by the Trust to have been a reasonable response in the circumstances.

Following detailed independent medical advice, I determined that the treatment received by the complainant was appropriate and furthermore, the waiting time he endured was not unreasonable and did not have an adverse effect on his condition. Although the waiting time was in excess of DHSSPS targets, the volume of patients attending at A&E was significant and the Trust had apologised to the complainant during local resolution, which I considered to be appropriate remedy in the circumstances and the complaint was not upheld. **(201100336)**

Western Health & Social Care Trust

Withdrawal of Domiciliary Care

This complaint relates to the withdrawal of Domiciliary Care by the Western Health and Social Care Trust (the Trust). The Trust suspended the complainant's Domiciliary Care Service in March 2008, in accordance with the Trust's Zero Tolerance Policy, following reports from carers regarding the complainant's behaviour towards them.

As part of the review of the complainant's service suspension, a reassessment of his needs was carried out in April 2008 by a senior social worker and a social work assistant. This reassessment determined that the complainant no longer met the criteria for ongoing Home Help provision. The complainant requested a review of this decision, which also upheld the original assessment. The

complainant complained to this Office about the initial decision to remove his domiciliary care, and about the two reassessments of his needs.

My investigation found that, although the Trust was correct in initially suspending Domiciliary Care due to the complainant's unacceptable language and behaviour towards his carer, it could have managed this suspension more appropriately, and it did have continuing responsibility for supporting the complainant during the period his services were suspended.

Regarding the reassessments, my investigation found that although the complainant did not appear to meet the Domiciliary Access Criteria which were operational at the time, the Trust should have conducted more thorough assessments of his needs and recorded these appropriately.

I concluded that these failings constituted maladministration and I have recommended that the Trust writes to the complainant to apologise for these shortcomings I have identified, and that it should carry out a further assessment of his current needs. I also recommended that the Trust should make a payment of £250 to the complainant in respect of the distress which these events have caused him. The Trust has accepted my recommendations. **(201000833)**

Health Service Providers – GP

Treatment of father

This is the case of a gentleman who battled the effects of several serious illnesses during the final years of his life and who began to suffer from recurrent chest problems, which affected his swallow and his ability to eat and drink. Following initial treatment at home from his GP, he was subsequently admitted to Erne Hospital where his condition deteriorated and he passed away in 2007.

The deceased gentleman's daughter complained to her father's GP Practice ('the Practice') about the level of care he received prior to his admission to Erne Hospital. It was her belief that had her father been sent for tests sooner, the underlying causes of his death would have been uncovered, and the unnecessary suffering he experienced prior to his death would have been avoided.

After an initial delay in her complaint to the Practice, she contacted this Office in 2009 and, as a result of the investigation of this case I recommended that the Practice apologise and make a payment in respect of its failure to follow the statutory complaints procedure. The Practice agreed with my recommendation and local resolution of the complaint resumed.

Subsequently, the complainant contacted this office again in 2010, as she remained dissatisfied with the Practice's response to her questions relating to her father's care, including not just the treatment he received and the timing and nature of his referral to hospital. In addition, she was not satisfied that the Practice had identified any proposals to avoid a repetition of the effects that affected her father.

Following a detailed investigation, and having obtained Independent Professional Advice, I did not uphold a number of the elements of the complaint. It was my view that, although referral for an emergency endoscopy could have been considered at an earlier point, the treatment option followed by the Practice was reasonable. Furthermore, I considered that the Practice acted appropriately in respecting the wishes of the complainant's father not to be admitted to hospital, and there is no evidence to suggest that had earlier tests been conducted, his life would have been extended.

However, I did uphold aspects of the complaint in relation to maintenance of medical records and good complaints handling. I identified some learning points for the Practice in this area, and reminded them of the best practice approaches outlined in the General Medical Council's 'Guidance on Good Practice', and the Health and Personal Social Services (HPSS) Complaints Procedure (succeeded by the Health and Social Care (HSC) Complaints Procedure in April 2009). In respect of these areas for improvement, I recommended that the Practice issue an apology to the complainant outlining the steps taken to prevent their

recurrence. The Practice accepted my recommendations. **(200900998)**

Removal from Practice List

I received a complaint about the decision made by a Medical Centre to remove the complainant from its practice list without warning and its failure to engage with the complainant despite efforts on her part to resolve the issue.

The removal of patients from a practice list must be informed by the Health and Social Services (General Medical Services Contracts) Regulations (Northern Ireland) 2004. I examined the actions of the Medical Centre to determine if it had followed the correct procedures as laid down under the regulations.

I found that the Medical Centre did not adhere to the regulations because it did not provide the complainant with any warning that she would be removed from the list, nor did it record any explanation of why the surgery decided not to issue the complainant with a written warning.

The issue regarding the Medical Centre's refusal to engage with the complainant was also examined, and I found that the Medical Practice failed to treat the complainant correctly, in addition to failing to comply with the Department of Health, Social Services and Public Safety's Guidelines on Complaints in Health and Social Care.

Consequently, I upheld the complaint and recommended that the Medical Centre provide the complainant with an apology for its failure to follow the regulations. I also recommended that the Medical Centre carry out a full audit of its complaints handling systems, procedures and literature and that all staff receive appropriate complaints management training. The Practice accepted my recommendations. **(201000288)**

Removals Protocol

In this case, a gentleman complained to me about the actions of his GP Practice (the Practice) in relation to his registration status, and the subsequent handling of his complaint.

Following a detailed investigation, I found that the Practice:

- failed to advise the complainant that it had set aside its Removals Protocol in 2006;
- omitted to consider and reach agreement in 2006 in respect of the complainant and his wife's registration status were they to change address again outside of the Practice area;
- did not have in place a mechanism to ensure reception staff were aware of its decision to set aside its Removals Protocol to allow the complainant and his wife to remain on the Practice list in 2006.

In respect of the Practice's complaints handling, I found that it failed to take into account the full circumstances and the background of the complaint during its investigation and adopted a defensive and non-conciliatory approach to the complainant. It did not provide the complainant with accurate information about the events in question in its response to his complaint or consider the complainant's perspective. In addition, the Practice did not clarify with the complainant whether or not he wished to engage further in local resolution upon receipt of a second letter from him.

I found that the complainant suffered injustice as a result of maladministration by the Practice and I recommended that the Practice provided him with a full written apology for the failings I identified, and in recognition of the distress, time and trouble caused to him. I also made a number of recommendations to the Practice in relation to its Removals Protocol, customer service and complaints handling. The Practice accepted my recommendations. **(201000345)**

GP Referral

I had previously investigated a complaint made by this complainant against the Northern Health and Social Care Trust, regarding the treatment of her late sister. In the course of that investigation, my Independent Professional Advisor (IPA) identified possible maladministration by the complainant's sister's GP, relating to a possible delay in re-referral to the Trust. I therefore decided to open

an investigation into the Practice and requested more in-depth IPA advice.

Overall, my IPA advised that the treatment received by the complainant's sister during the final months of her life was appropriate and reasonable. However, I also determined that there was a slight delay in referral, and that her condition meant that she required urgent referral for further investigation as per the National Institute of Clinical Excellence (NICE) Guidelines. However, the GP advised that he had simply complied with the equivalent guidance issued by the NI Cancer Network (NICAN), which did not require urgent referral in the event of such symptoms, unlike those issued by NICE.

My IPA explained that the absence of this requirement in the NICAN Guidance resulted in the guidance not being up to date. I determined that the GP could not be held responsible for this delay. I therefore undertook to write to the Chair of NICAN to bring the discrepancy identified within this investigation to that forum's attention.

My IPA also suggested that the limited sessional commitment of complainant's sister's GP, who was a locum employed by the Practice on a part-time basis, may have contributed to the delay. However, in accordance with the advice of the IPA and taking account of the wider circumstances of the case, I determined that this slight delay (5 days) did not constitute maladministration. Had the complainant's sister been referred immediately, it was unlikely that she would have received a significantly earlier appointment, and it would not have altered the eventual outcome of her illness. I did however remind the Practice of the need to have robust hand-over arrangements between staff, as required by GMC Guidance. **(201001255)**

Difficulty in securing an appointment with the GP

I received a complaint from a gentleman regarding the difficulty his wife had experienced in getting an appointment to see a doctor at their local GP Practice; the ensuing consultation with the doctor at which he alleged that the doctor's manner and attitude was both irate and aggressive towards his wife; and the Practice's handling of his subsequent complaint.

The complainant noted that three phone calls were required to the Practice in order for arrangements to be made for his wife to speak with a doctor. After the third telephone call, arrangements were made for a doctor to call her back in the afternoon.

I did not uphold this aspect of the complaint as in my view there is also a responsibility on the patient to identify their specific concerns if at that time, they are not satisfied with the advice or the date of the appointment offered to them. However, I recommended that the Practice leaflet be amended to provide more clear advice and information for patients ringing after 10.30am. I also emphasised that it is also important that staff who are responding to requests are properly supported and trained for what can be a crucial role, and receptionists should be aware of how and when to elicit information from patients and also to explain alternative options to them such as the possibility of speaking to a doctor. I found that the complainant's wife did not suffer injustice as a consequence of the Practice response on this occasion. Once the urgency of her condition was established, she was seen quickly and in line with the Practice procedures.

In relation to the handling of the complaint by the Practice, the Practice acknowledged some 'minor inaccuracies', but it did not apologise. This represents poor administrative practice and is not in keeping with the Principles of Good Complaint Handling. Further, I noted that the Practice failed to keep minutes of the ensuing meeting between the complainant and another doctor at the Practice at which attempts were made to resolve the complaint. It is important to have a written record of such discussions as this helps avoid any later challenge that may arise to what occurred. I recommended that the Practice issued a letter of apology for its failure to fully address the issues of the complaint in the first instance, and then having acknowledged the errors in its response, for failing to apologise for them.

With regard to the complainant's wife's consultation with the doctor, I must stress that it is difficult to make a determination in respect of complaints which concern conversations between two individuals. This is often due to a lack of objective, independent evidence, the absence of which

prevents a reliable determination in favour of either version of events. I fully appreciate that this may be frustrating for all the parties concerned however it is essential that the findings of any of my investigations are based on sound, objective, supported evidence.

Finally, in terms of clarity and perceived fairness, I also recommended that the Practice should ensure all staff, including front-line staff, are trained in dealing with, and managing, complaints, and should make Practice leaflets and Complaints leaflets more accessible to patients. **(201100056)**

Aggrieved at service received from GP

This complaint relates to the service that the complainant received from her GP Practice. In particular, the complainant was unhappy that she had not been referred for specialist consultations on three occasions, and that there had been a delay in the return of her DLA report.

The GMC guidelines 'Good Medical Practice' set out the principles and values of good practice for doctors, and advises the public of the level of service it can expect from doctors.

I found that the complainant had not been referred for specialist consultations on three occasions, and that there was a delay in the return of her DLA report. I considered that the GP Practice did not provide a satisfactory explanation for the poor service received by the complainant.

I recommended that the GP Practice apologise to the complainant and provide her with a payment of £250 for the poor service she received, which it did. **(201100310)**

NI Ambulance Service Trust

Treatment and care

I received a complaint from a lady concerning the treatment provided to her late aunt, by the Northern Ireland Ambulance Service (NIAS). NIAS had conducted an investigation relating to the events surrounding the death of the complainant's aunt and produced a report in response to the complaint about the treatment provided to the deceased by the Ambulance crew. The complainant was dissatisfied with the NIAS handling of her complaint.

During my investigation, I examined all of the documentation relating to the NIAS handling of the complaint, including the deceased's Accident and Emergency hospital medical records. To assist in my consideration of the case I also had the benefit of detailed advice from my Independent Professional Advisor (IPA) who is employed outside Northern Ireland.

With regard to the NIAS handling of the complaint, I found that the complainant was not kept up to date on the progress of her complaint, and indeed it was she who had to contact NIAS to ascertain the status of her complaint. I reminded the NIAS of the need to keep complainants informed on a regular basis of progress on a complaint. I advised the Chief Executive (CE) that he may find it helpful to refer to the guidance set out in my booklet "Rights, Responsibilities and Redress - A Framework for Effective Complaint Handling", and in particular the section "The Complaints Procedure – Its Purpose and Aims". I recommended that the CE issue a letter of apology to the complainant for its failure in keeping her informed. I was however satisfied that the time taken by the NIAS in dealing with this complaint was not unreasonable.

As a result of my findings, the CE of NIAS assured me that he had asked that the NIAS Complaints Procedure be reviewed to address the issue identified in my investigation. I also suggested that the CE consider reviewing the training given to NIAS staff regarding 'personal' introductions at a call particularly when the call is to someone's home as there is no reference in the training that it is dependent on each individual situation whether or not a NIAS crew will provide their names. I welcomed the assurance given to me by the CE that he had asked that the NIAS Clinical Training Department review training regarding 'personal introductions' paying due regard to the issue raised in the complaint. I was reassured both by the detail of the response and the commitments given to address the issues identified in my investigation.

The complainant had also raised concerns about the treatment provided to her aunt by the Ambulance crew and in particular with regard to the use of oxygen. Having considered all the evidence available to me, and taking into account the advice from my IPA, I was satisfied that the NIAS paramedics treated the complainant's aunt in a clinically appropriate way, which was consistent with all the relevant guidance and training. I concluded that no alternative approach which the Ambulance crew could have adopted would have altered the outcome in this case. **(201000725)**

Appendix B

Key Activities 2011/12 and Financial Summary

Other Key Areas Addressed in 2011/12

My Corporate Plan covering the period 2010-13 was issued in April 2010 following a major review of the Office. The Strategic Objectives remain in this reporting year, and as outlined in the Plan, relate to three discrete areas –

- Benefits for Individuals
- Improving Public Services
- Modernising the Ombudsman Office

Benefits for Individuals

To further enhance our service to the public, we have developed a new validations and investigations policy which aims to ensure that our investigation resources are used effectively and proportionately. As a result of internal restructuring, the investigation of complaints in the social care sector were separated from the health care complaints and placed in a new Directorate, to ensure a greater focus on this area of work given the continuing increase in health related cases. A number of study visits to the Welsh and Irish Ombudsman's Offices were undertaken by senior staff to examine how best to use resources to meet the public's perception of our service. These study visits have helped inform the proposed realignment of resources necessary to meet the challenges of implementing the proposed new legislation.

Improving Public Services

As part of my aim to improve public services, I have, where appropriate, provided general guidance to bodies in jurisdiction. In addition, I encourage these bodies to seek to resolve complaints locally where possible. With these twin objectives in mind, in 2011 I issued a guidance leaflet on how to make an apology. The power of an apology must not be underestimated.

Complainants often come to my office and advise me that all they seek is a meaningful apology. Also, in individual cases, I make specific recommendations to bodies where I find maladministration and injustice in relation to individual complaints to my Office. These recommendations can include an apology, a change in practice, or a payment. In total, I made 69 recommendations in 2011/12 and I am pleased to advise that in only 4 instances, involving recommendations of payments by General Practitioners, these were not met. The issue of my power to make recommendations for financial redress in cases involving General Practitioners was the subject of a judicial review in this year. I await the High Court's judgement in this matter.

Modernising the Ombudsman's Office

In June 2010, the Office of the First Minister and Deputy First Minister (OFMDFM) agreed to sponsor a bill to refresh and reform the legislation underpinning my role as Northern Ireland Ombudsman. The current legislation is based on two acts of Parliament made in 1969 and in 2004. OFMDFM commissioned an independent review of my Office. The Deloitte Review made substantial recommendations in relation to the consolidation of the roles of the Assembly Ombudsman and the Commissioner for Complaints. On 15 June 2011, the Scottish, Welsh and Irish Ombudsmen gave evidence to the OFMDFM Committee on their respective jurisdictions. Both myself and my deputy have given evidence on several occasions concerning the proposed changes in legislation. I am pleased to note the progress to date and hope to see the Ombudsman Bill before the Assembly in the coming financial year.

A key project in 2011 was the updating of the case management system. The old system (CHAS) did not provide performance management data. I am pleased to note the significant achievement of the project team who worked hard to achieve full implementation of the new bespoke case management system by 1 April 2012.

Financial Summary

The Assembly Ombudsman for Northern Ireland and the Northern Ireland Commissioner for Complaint's (AOCC) full Resource Accounts 2011/12 will be laid before the Northern Ireland Assembly in July 2012 and will be available on our website at www.ni-ombudsman.org.uk.

Summary Financial Statements for the year ended 31 March 2012

The following Financial Statements are a summary of the information extracted from the AOCC's full annual Resource Accounts for 2011/12. The full annual Resource Accounts and auditors report should be consulted for further information.

The Comptroller and Auditor General has given and unqualified audit opinion on AOCC's Resource Accounts.

Financial Review

The Net Total Resource allocated to the AOCC was £1.759 million, with the Net Cash Requirement being £1.779 million approved through the annual Main Estimate and Supplementary Estimate process by the Northern Ireland Assembly.

The actual net resource outturn was £1.691 million, £68k less than the estimate, with the actual net cash requirement being £1.703 million, £76k less than the estimate. This variance was primarily due to an underspend resulting from the non determination of a judicial action, which was heard in December 2011 and January 2012.

Capital expenditure amounted to £79k, £5k less than the estimated figure.

Staff costs equated to 75.5% of the actual total resource requirement, with the remainder being split between property rent and rates, premises expenses, travel and subsistence, consultancy and other general office expenditure.

The Ombudsman's Office is committed to the prompt payment of bills for goods and services received in accordance with the Better Payment Practice Code. Unless otherwise stated in the contract, for invoices not disputed, payment is due within 30 days after receipt of invoice or delivery of goods and services, whichever is later. This was met in 99.5% of cases compared with 99.7% in the previous financial year.

In response to the current economic position, the Department for Business Enterprise and Regulatory Reform (BERR) announced on 21 October 2008 that:

"Central Government has committed to paying businesses within 10 days - and we're urgently speaking to the wider public sector to extend this commitment."

The Office met the 10 day prompt payment directive from the date of approval of invoice in 99.8% of cases the same level as in the previous financial year.

Summary of Resource Outturn 2011/12

	2011/12 £000 Estimate			Outturn				2010/11 £000 Outturn
Request for Resources	**Gross Expenditure**	**AR**	**Net Total**	**Gross Expenditure**	**AR**	**Net Total**	**Net Total outturn compared with Estimate: saving/(excess)**	**Net Total**
A	1,759	-	1,759	1,691	-	1,691	68	1,626
Total resources	**1,759**	**-**	**1,759**	**1,691**	**-**	**1,691**	**68**	**1,626**
Non-operating cost AR	-	-	-	-	-	-	-	-

Net cash requirement 2011/12

			2011/12 £000 Net total outturn compared with estimate: saving/ (excess)	2010/11 £000
	Estimate	**Outturn**		**Outturn**
Net cash requirement	1,779	1,703	76	1,610

Statement of Comprehensive Net Expenditure

for the year ended 31 March 2012

	2011/12 £000				Restated 2010/11 £000
	Staff Costs	**Other Costs**	**Income**	**Total**	
Administration Costs (Request for resources A)					
Staff costs	1,277			1,277	1,194
Other administration costs		590		590	605
Operating income			(1)	(1)	-
Totals	**1,277**	**590**	**(1)**	**1,866**	**1,799**
Net Operating Cost				**1,866**	**1,799**

Statement of Financial Position

as at 31 March 2012

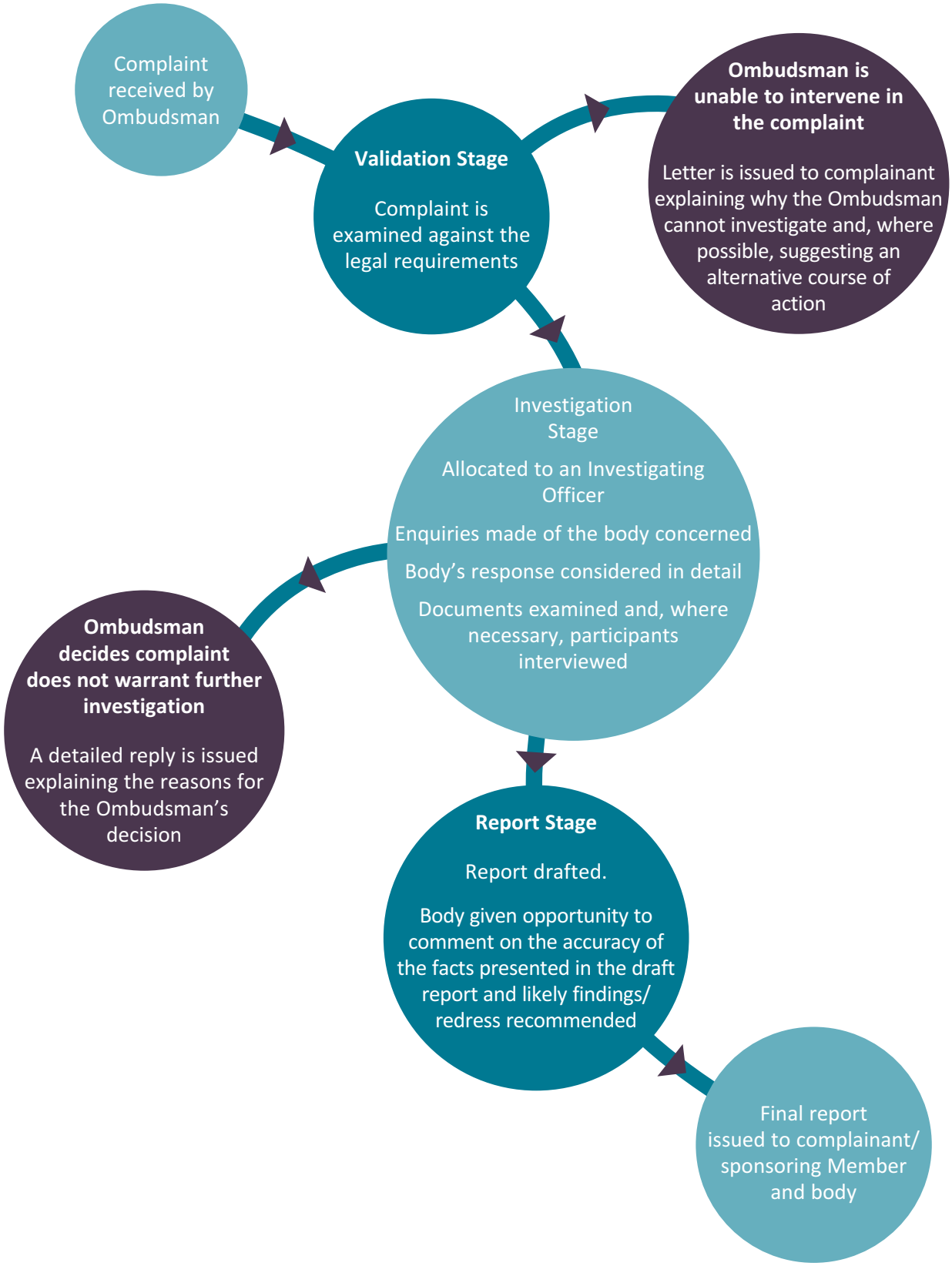
	2012 £000	2011 £000	2010 £000
Non-current assets			
Property, plant and equipment	34	58	55
Intangible assets	97	32	45
Receivables falling due after more than on year	-	-	-
Total non-current assets	131	90	100
Current assets			
Inventories	-	-	-
Trade and other receivables	63	75	95
Cash and cash equivalents	33	5	12
Total current assets	96	80	107
Total assets	227	170	207
Current liabilities			
Trade and other payables	(68)	(34)	(41)
Total current liabilities	**(68)**	**(34)**	**(41)**
Non-current assets plus/less net current assets/liabilities	**159**	**136**	**166**
Non-current liabilities			
Provisions	-	-	(26)
Total non-current liabilities	**-**	**-**	**(26)**
Assets less liabilities	159	136	140
Taxpayers' equity:			
General fund	142	119	125
Revaluation reserve	17	17	15
Total taxpayers' equity	**159**	**136**	**140**

Appendix C

Handling of Complaints

Handling of Complaints

How is a Written Complaint Handled by the Ombudsman's Office?



THE PROCESS

Validation Stage

Each complaint is checked to ensure that:

- the body complained of is within jurisdiction;
- the matter complained of is within jurisdiction;
- it has been raised already with the body concerned;
- it has been referred to me by an MLA (where necessary);
- sufficient information has been supplied concerning the complaint; and
- it is within the statutory time limits.

Where one or more of the above points are not satisfied a letter will issue to the complainant / MLA explaining why I cannot investigate the complaint. Where possible, this reply will detail a course of action which may be appropriate to the complaint (this may include reference to a more appropriate Ombudsman, a request for further details, reference to the complaints procedure of the body concerned, etc.).

Where the complaint is found to satisfy all of the points listed above, it is referred to the Investigation Stage (see below). The Office target for the issue of a reply under the Validation Stage is currently 15 working days.

Investigation Stage

The purpose of an investigation is to ascertain whether there is evidence of maladministration in the complaint and how this has caused the complainant an injustice. The first step will generally be to make detailed enquiries of the body concerned. These enquiries usually take the form of a written request for information to the chief officer of the body. In Health Service cases it may also be necessary to seek independent professional advice. Once these enquiries have been completed, a decision is taken as to what course of action is appropriate for each complaint. There are three possible outcomes at this stage of the investigation process:

a. where there is no evidence of maladministration by the body – a reply will issue to the complainant / MLA explaining that the complaint is not suitable for investigation and stating the reasons for this decision;

b. where there is evidence of maladministration but it is found that this has not caused the complainant an injustice – a reply will issue to the complainant / MLA detailing my findings and explaining why it is considered that the case does not warrant further investigation. Where maladministration has been identified, the reply may contain criticism of the body concerned. In such cases a copy of the reply will also be forwarded to the chief officer of the body; or

c. where there is evidence of maladministration which has apparently also led to an injustice to the complainant – the investigation of the case will continue (see below).

If, at this stage of the investigation, the maladministration and the injustice caused can be readily identified, I will consider whether it would be appropriate to seek an early resolution to the complaint. This would involve me writing to the chief officer of the body outlining the maladministration identified and suggesting a remedy which I consider appropriate. Where the body accepts my recommended remedy, the case can be quickly resolved. However, should the body not accept my recommendation or where the case would not be suitable for early resolution the detailed investigation of the case will continue. This continued investigation will involve inspecting all the relevant documentary evidence and, where necessary, interviewing the complainant and the relevant officials. Where the complaint is about a Health Service provider, and relates to their clinical judgement, professional advice will be obtained where appropriate from independent clinical assessors. At the conclusion of the investigation the case will progress to the Report Stage.

Report Stage

I will prepare a draft Report containing the facts of the case and my likely findings. The body concerned will be given an opportunity to comment on the accuracy of the facts as presented, my likely findings and any redress I propose to recommend. Following receipt of any comments which the body may have I will issue my final Report to both the complainant / MLA and to the body. This is a lengthy exercise as I must be satisfied that I have all the relevant information available before reaching my conclusion.

In complaints which are identified for full investigation, the Office target is to complete the draft report in 80% of cases within 12 months or less.

Appendix D

Summary of the Principles of Good Administration

Principles of Good Administration

Good administration is more than an absence of maladministration. My consideration of whether the actions of a public body constitute maladministration will often include reference to the Principles of Good Administration. Maladministration is not defined in law but can include broken promises, delay, failure to follow procedures or the law, misleading or inaccurate statements, failure to investigate, bias, incorrect action or failure to take any action, inadequate record-keeping, or failure to reply.

These Principles were established through the collective experience of public sector Ombudsmen affiliated to the Ombudsman Association (previously known as the British and Irish Ombudsman Association). They have been accepted by government as representing the standard of performance expected of government officials. They are also endorsed in the DFP document Managing Public Money Northern Ireland. The Principles serve as a benchmark of good administrative practice against which the standard of service provided by a public body in any given complaint brought to my Office can be tested. I have provided a summary of the Principles below.

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

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

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

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

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

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

A full copy of the Principles is available at:http://www.ombudsman.org.uk/__data/assets/pdf_file/0013/1039/0188-Principles-of-Good-Administration-bookletweb.pdf

Appendix E

Staff Organisation Chart

Tom Frawley
Ombudsman

Dawn Roberts
PS to Ombudsman and Deputy

Marie Anderson
Deputy Ombudsman

John MacQuarrie
Director of Standards and Special Projects

Andrea McIlroy
Legal Officer

Sean McKenna
Director of Investigations Planning & Social Care Complaints

Michaela McAleer
Director of Investigations Health Complaints

Claire McIlhatton
Director of Investigations Housing & Misc. Complaints

Lynne Davison
Corporate Services Manager

Investigating Officers
Gillian Coey
Ian Groves
Paul Creery
Jeffrey McWatters
Madeline McCausland

Investigating Officers
Nicola Graham
Jenny Mahood
Martin McCourt
Nuala McNamee
Grainne Rice
Caroline Walton
Alan Weir
Joanne Matthews

Investigating Officers
Nigel Bonar
Marian Kerr
Anne Jamison

Finance Officer
Anne Scott

Administrative Support Team
Paul McKeever
Cathy Gallagher
Ashleigh Smyth
Christopher Wightman

Contacting the Office

Access to my office and the service I provide is designed to be user-friendly. Experienced staff are available during office hours to provide advice and assistance. Complaints must be put to me in writing either by letter or by completing my complaint form. The complainant is asked to outline his/her problem and desired outcome. Complaints can also be made to me by email and online. The sponsorship of a Member of the Legislative Assembly (MLA) is required when the complaint is against a government department or one of their agencies. If a complainant is unable for whatever reason to put his complaint in writing my staff will provide assistance either by telephone or by personal interview. I aim to be accessible to all.

My information leaflet is made widely available through the bodies within my jurisdiction – libraries, advice centres, etc. It is available in large print form and on CD. In addition, anyone requiring assistance with translation should contact my office.

You can contact my Office in any of the following ways:

By phone: 0800 34 34 24 (this is a freephone number)
or 028 9023 3821

By fax: 028 9023 4912

By email to: ombudsman@ni-ombudsman.org.uk

By writing to: The Ombudsman
Freepost BEL 1478
Belfast
BT1 6BR

By calling, between 9.30am and 4.00pm, at:

The Northern Ireland Ombudsman's Office
33 Wellington Place
Belfast
BT1 6HN

Further information is also available on my website:

www.ni-ombudsman.org.uk

The website gives a wide range of information including a list of the bodies within my jurisdiction, how to complain to me, how I deal with complaints and details of the information available from my Office under our Publication Scheme.

Northern Ireland Ombudsman

Distributed by and available from:

The Northern Ireland Ombudsman
33 Wellington Place
Belfast
BT1 6HN

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