Northern Ireland Ombudsman

# Annual Report

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

2012~2013

# 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 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 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 2012/13

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

# Contents

# SECTION 1

## The Year in Review

# The Year in Review

This is the 13th and final year in which I will have the honour and the privilege of recording the work and performance of my office as Assembly Ombudsman for Northern Ireland and Northern Ireland Commissioner for Complaints. As Assembly Ombudsman I have responsibility for investigating complaints of maladministration in relation to the actions of 12 of 13 Northern Ireland departments. I also investigate complaints about administrative failures in their statutory agencies. In that role I can also investigate complaints about North-South implementation bodies and the administrative failures of a number of tribunals that operate in Northern Ireland. The Commissioner for Complaints jurisdiction is equally complex; covering complaints of poor administration made against housing, local government, health and social care bodies and a diverse range of other public authorities. My health jurisdiction allows me to assess the clinical judgement of health professionals including hospital doctors, consultants, GPs, dentists and opticians, without first finding maladministration. As a second tier complaint handler, I usually only investigate when the internal complaint process of the relevant body has been exhausted.

## Emerging Trends 2012/13

In the year 2012/13 I received a total of 668 written complaints in relation to all of the bodies in my jurisdiction. This represents an increase of 4% on the 2011/12 total of written complaints received. In relation to my Assembly Ombudsman jurisdiction there were an increased number of complaints about Northern Ireland departments. There was also a slight decrease (2%) in the number of complaints received in my jurisdiction as Northern Ireland Commissioner for Complaints. However, the largest increase in written complaints received was experienced in my health and social care jurisdiction. Health and social care complaints represented 38% of the total, making them the largest single category of complaints. It is noteworthy that this represented an increase of 21% in health and social care complaints on the 2011/12 figure. A discrete section of this report details the themes and trends emerging from each area of complaint at sections 2, 3 and 4 below.

In relation to inquiries and contact with my office, that relate to complaints outside my jurisdiction, I am pleased to note a decrease in the number of contacts made overall from 2702 in 2009/10 to 1875 in the reported year. In my view, this reduction in misdirected complaints can be explained in two ways. Firstly, bodies are increasingly aware of the need to signpost complainants correctly to my office at the end of their complaints procedure. Secondly, since 2009 my office has published information on my role as Ombudsman and on complaints handling generally. I am persuaded also that the publication of the Alternative to Court booklet in 2011 has helped to clarify my role to members of the public and those advocacy organisations offering advice to complainants about central, local government, health, social care and housing matters.

## Significant Cases

The breadth of my jurisdiction has been highlighted in three significant investigations in the year being reported on. In relation to planning matters, I investigated a complaint submitted by the residents living in properties adjacent to the Cavanacaw Goldmine. I found that the Department of the Environment Planning Service had failed to enforce planning conditions and this had resulted in substantial inconvenience, upset and distress to the residents who had complained to my office. In this case, I recommended financial redress of £10,000 to each of the residents who had complained to me. I am pleased to acknowledge that the Department of the Environment accepted my recommendations in full. In a complex and very sad health case, I found that both primary and secondary care levels of the health service had failed the family of a deceased patient both in relation to diagnosis by the General Practitioner and through a failure in care by two Health and Social

Care Trusts (Belfast and South East) in which that patient had also received care and treatment. Again, the financial redress in that case was significant and amounted to £25,000 in total, which again I am pleased to record was accepted by each of the Trusts involved. Finally, in December 2012 I issued a lengthy, detailed and complex report on the failings by the Department of Enterprise, Trade and Investment (DETI) to properly fulfil its registration function which impacted on the re-registration of the failed Presbyterian Mutual Society (PMS). While I was satisfied that the government package of compensation remedied any injustice sustained by PMS savers, I made substantive recommendations in relation to the approach to registration by DETI in order to avoid similar failings in its registration function in the future. Again, I am pleased to record that DETI accepted my recommendations in full.

## Modernising the Office

On 1 April 2012 a new case handling system went live in my office and throughout the year my staff worked to develop and enhance performance reporting systems developed from that case handling system. In addition, substantial work was undertaken to move my office from a 'specialist' approach to investigations to a more generic approach in order to ensure a fairer balance of workload, more efficient workflows and timely completion of investigations. Finally, preparatory work for the establishment of a 'front of office team' to provide early determination and resolution of complaints was undertaken in the final quarter of the year being reported on. Taken together, these developments will, I believe, ensure that our service to the public deals more effectively and efficiently with their complaints ensuring that each complaint is addressed in a way that is proportionate to the issues complained of and being investigated. It is not possible for my office to investigate every complaint, but where resolution is possible the front of office team will endeavour to achieve an early resolution. This will in turn, in my view, ensure a more effective and efficient use of the finite resources available to my office.

## Ombudsman Association Annual Meeting 2012

I was honoured to play host to the 19th Ombudsman Association Annual Meeting and Dinner, which was held in Belfast on 17&18 May 2012. The event brought together public service and private sector Ombudsmen from across the United Kingdom, Ireland and Europe. Speakers included Emily O'Reilly, Ombudsman for Ireland, Peter Tyndall, Public Services Ombudsman for Wales, as well as the Lord Chief Justice for Northern Ireland, Sir Declan Morgan, and the Chief Northern Ireland Human Rights Commissioner, Professor Michael O'Flaherty.

## Looking to the Future

In my annual reports since 2010, I have identified progress on the legislation to refresh and reform my office and my role. I am pleased to note that the OFMDFM Committee continue to develop the policy platform underpinning the proposed new legislation. I am grateful to the Committee Chair, Clerk and staff, in their continued support and commitment to this complex and challenging task.

In recent reports I have highlighted the importance of good record keeping and also complaints across a wide spectrum of bodies where failures in this regard have led to a finding of maladministration. In the year being reported on, further initiatives have been introduced in relation to extending the functions of my office to include matters such as complaints about judicial appointments and also a proposal is being considered to include in the jurisdiction of the Office complaints made in relation to the proposed mandatory Code of Conduct for Councillors. I am grateful to the officials in the Department of Justice and the Department of the Environment (Local Government) for their continued support and diligence in examining with my Office the implications of these proposed extensions to the jurisdiction of the Office.

## Number of Contacts 2012/13

Written Complaints (including electronic transmission) – **742**

Enquiries – **1133**

## Breakdown of Written Complaints to the Office 2012/13

Assembly Ombudsman – **233**

Commissioner for Complaints – **182**

Health and Social Care – **253**

Outside Jurisdiction – **74**

## Breakdown of Enquiries to the Office 2012/13

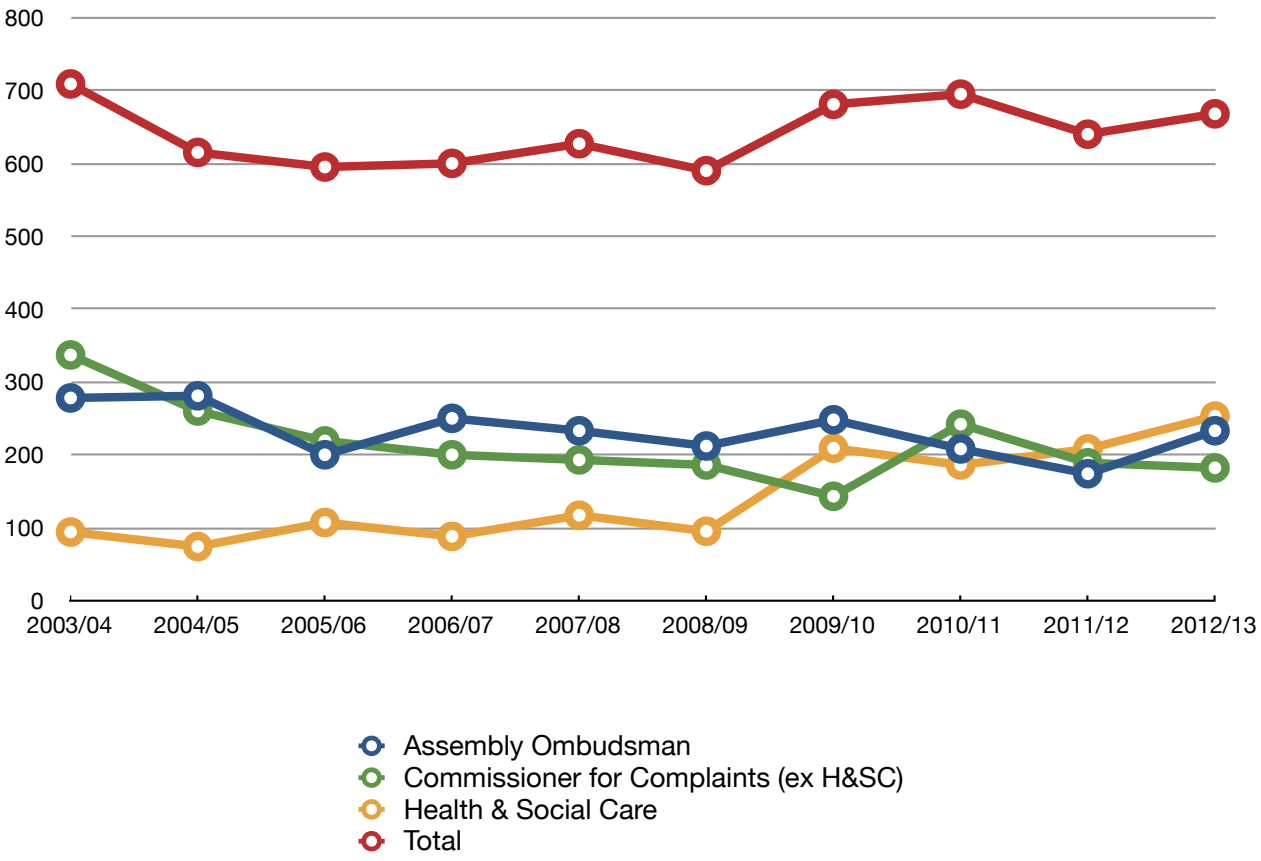
Assembly Ombudsman – **58**

Commissioner for Complaints – **158**

Health and Social Care – **74**

Outside Jurisdiction – **843**

## Complaints Received 2003/4 - 2012/13



# SECTION 2

## Annual Report of the Assembly Ombudsman for Northern Ireland

In my role as Assembly Ombudsman, I investigate complaints against Government Departments and their agencies. Issues in relation to the planning process continue to be the largest area of complaints referred to my office by MLAs with an increase of 10 to 53 in total being received during 2012/13. Of particular concern was a case brought by residents living adjacent to the Cavanacaw Goldmine in Omagh. My investigation identified what I considered to be, a major system failure by the Department of the Environment Planning Service (Planning Service (now known as the Department of the Environment Planning and Local Government Group)) about the removal of rock from a mine. It took Planning Service over twelve months to issue an enforcement notice which required the company to cease removal of the rock. Planning Service permitted the company to remove in excess of 8000 truck loads of rock, by the operator's own admission, without any assurance that sufficient rock remained to restore the site to its original state. I also found that Planning Service failed to monitor whether the company operating the site was complying with planning conditions, a failure I considered to represent maladministration. Given the considerable loss of amenity, inconvenience and severe distress to the complainants during the removal of rock, I recommended that the Deputy Secretary of the Department of the Environment should personally issue a letter of apology, along with a payment of £10,000 to each of the three complainants. I also recommended that a reassessment of the condition of the mine be carried out within six months of the date of my report and that Planning Service should report its findings both to me and the complainants.

I referred in my Annual Report last year to the issue of records management particularly as 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. Of particular significance this year was a second case concerning the destruction of records by the Education and Training Inspectorate (ETI). The complaint in this case was that ETI failed to recognise the complaint; that it had destroyed the evidence base of a follow-up school inspection it had undertaken; and that the reporting system used for the inspection had several inaccuracies. My investigation found evidence of maladministration on the part of ETI in relation to the premature destruction of the evidence base of the follow-up school inspection. I was satisfied that this action meant that the complainant was effectively denied her fundamental right to challenge and question the detail of the matters which gave rise to the criticism. I also identified maladministration in ETI's complaints handling process, although I was satisfied that the complainant did not sustain an injustice as a consequence of that failing. I recommended that the follow-up inspection report should be withdrawn as it could not be relied upon. I am pleased to note that the Permanent Secretary of the Department of Education accepted the findings of my investigation and my recommendations. The ETI has also taken practical measures to improve its complaints handling process.

Another significant complaint submitted to me during the year that related to a Government Department was a complaint made against the Department of Enterprise, Trade and Investment (DETI). The complaint related to the oversight and governance of Industrial and Provident Societies under the provisions of the Industrial and Provident Societies Act (NI) 1969 (the 1969 Act). The complainant alleged that DETI failed to subject the PMS to an adequate level of scrutiny and, as a result, the Department failed to identify that the PMS had extended its activities to include what was held by the Financial Services Authority (FSA) to be 'banking' services. Having conducted a detailed investigation I found that in order to meet the provisions of the 1969 Act, it was incumbent on DETI to proactively examine the annual returns and accounts of Industrial and Provident Societies in order to satisfy itself that a society is adhering to the limitations of activity placed on it by its rules and the legislative requirements of the 1969 Act and to further satisfy itself that a society is not involved in 'regulated' activities. I concluded that the examination by DETI of the PMS Annual Returns involved a very limited administrative check which I regarded as being wholly inadequate for the purposes of DETI satisfying itself in relation to the above requirements. I found that the failure of DETI to examine in detail the information provided within the PMS Annual Return, in particular the accounts information, and to take this into account in informing its decision to continue to register the PMS, constituted maladministration. However, I found no basis that would allow me to determine that this maladministration caused the financial turmoil that befell the PMS and eventually led to its collapse in 2008. I did recognise that there were other parties who had supervisory and governance responsibilities in and for the PMS namely its Directors and its Auditors. I recommended that DETI revisit the procedures used in order to ensure that they meet its statutory responsibilities and further, to inform me of all measures introduced to

prevent a repetition of this maladministration. I also recommended to DETI that it should issue general guidance on the registration process which should be publicly available. I am pleased to say that DETI has accepted my findings and recommendations.

A breakdown of the number and nature of complaints received under the Assembly Ombudsman jurisdiction is set out below. I have included a breakdown of the 'Complainant Association' of written complaints received during the year. This is a new category, which relates to the complainant's relationship to the service provided by the Authority that they are complaining about.

## Written Complaints Received in 2012/13

A total of **233** complaints were received during 2012/13, 59 more than in 2011/12.

## Breakdown of Total Complaints

### Caseload for 2012/13

| | |
|---|---|
| Number of Written Complaints Received | **233** |
| Number Determined at Complaint Validation Stage | **219** |
| Number Determined at Preliminary Investigation Stage | **47** |
| Number Determined at Detailed Investigation Stage | **21** |
| Number of Complaints/ Investigations Ongoing at 31 March 2013 | **54** |

## Written Complaints Received in 2012/13 by Authority Type

| | |
|---|---|
| Government Departments – | **113** |
| Agencies of Government Departments – | **98** |
| Tribunals – | **4** |
| N/S Implementation Bodies – | **0** |
| Other Bodies Within Jurisdiction – | **18** |

## Written Complaints Received in 2012/13 by Complainant Association

| | |
|---|---|
| Benefit Claimant – | **22** |
| Complainant / Other – | **107** |
| Customer – | **19** |
| Employee – | **24** |
| Grant Applicant – | **4** |
| Non-resident Parent – | **8** |
| Parent with Care – | **4** |
| Planning Applicant – | **9** |
| Planning Objector – | **36** |

# Recommendations in Cases Determined

| Case No | Body | Issue of Complaint | Recommendation |
|---|---|---|---|
| 13208 | Social Security Agency | Policies and Procedures | Apology |
| 13647 | Land & Property Services | Policies and Procedures | Payment of £200 |
| 13708 | Land & Property Services | Policies and Procedures | Apology; Payment of £200 |
| 201100820 | Department of Education | Complaint Handling | Action by body |
| 201100776 | Department for Employment and Learning | Policies and Procedures | Financial redress of £2,080 |
| 201100669 | NI Prison Service | Complaint Handling | Apology; Payment of £150 |
| 201100507 | DOE Planning & Local Government Group | Policies and Procedures | Apology; Payment of £250 |
| 201100483 | Department of Justice | Complaint Handling | Apology; Payment of £500 |
| 201100463 | DOE Planning & Local Government Group | Policies and Procedures | Apology; Payment of £1,500 |
| 201100272 | DOE Planning & Local Government Group | Policies and Procedures | Apology; Payment of £2,250 |
| 201100159 | DOE Planning & Local Government Group | Enforcement / Legal Action | Apology; Payment of £1,500 |
| 201100116 | Appeals Service | Delay | Apology; Payment of £750; Action by body |
| 201000885 | DOE Planning & Local Government Group* | Policies and Procedures | Apology Payment of £500 |
| 201000849 | DOE Planning & Local Government Group* | Policies and Procedures; Enforcement / Legal Action | Apology; Payment of £10,000; Action by body |
| 201000848 | DOE Planning & Local Government Group* | Policies and Procedures; Enforcement / Legal Action | Apology; Payment of £10,000; Action by body |
| 201000847 | DOE Planning & Local Government Group* | Policies and Procedures; Enforcement / Legal Action | Apology; Payment of £10,000; Action by body |
| 201000832 | Department of Enterprise, Trade & Investment | Policies and Procedures | Action by body |

* Previously recorded as the DOE Planning Service

# Statistical Information

## Analysis of Written Complaints Received in 2012/13

| | Received | Determined at Complaint Validation Stage | Determined at Preliminary Investigation Stage | Determined at Detailed Investigation Stage | Ongoing at 31/03/13 |
|---|---|---|---|---|---|
| Government Departments | 113 | 102 | 23 | 17 | 37 |
| Agencies of Government Departments | 98 | 94 | 16 | 2 | 12 |
| Tribunals | 4 | 4 | - | 1 | - |
| North / South Implementation Bodies | - | 1 | - | - | - |
| Other Bodies | 18 | 18 | 8 | 1 | 5 |
| **TOTAL** | **233** | **219** | **47** | **21** | **54** |

## Analysis of Written Complaints About Government Departments

| | Received | Determined at Complaint Validation Stage | Determined at Preliminary Investigation Stage | Determined at Detailed Investigation Stage | Ongoing at 31/03/13 |
|---|---|---|---|---|---|
| DARD | 10 | 9 | 1 | - | 2 |
| DCAL | 2 | 2 | - | - | 1 |
| DE | 6 | 4 | 2 | 1 | 3 |
| DEL | 5 | 4 | 1 | - | 1 |
| DETI | - | - | - | 1 | - |
| DFP | 7 | 6 | 1 | - | 3 |
| DHSSPS | 4 | 4 | - | - | - |
| DOE | 1 | 1 | - | - | - |
| DOE (P&LGG) | 52 | 47 | 12 | 11 | 23 |
| DOJ | 2 | 2 | 2 | 1 | - |
| DRD | 4 | 4 | 2 | 3 | 1 |
| DSD | 5 | 4 | - | - | 1 |
| DSD (CMED) | 14 | 14 | 2 | - | 2 |
| OFMDFM | 1 | 1 | - | - | - |
| **TOTAL** | **113** | **102** | **23** | **17** | **37** |

## Analysis of Written Complaints About Agencies of Government Departments

| | Received | Determined at Complaint Validation Stage | Determined at Preliminary Investigation Stage | Determined at Detailed Investigation Stage | Ongoing at 31/03/13 |
|---|---|---|---|---|---|
| Compensation Services | 3 | 3 | 2 | 1 | - |
| Driver & Vehicle Agency | 12 | 12 | 1 | - | 1 |
| Land & Property Services | 24 | 23 | 6 | - | 3 |
| NI Environment Agency | 2 | 2 | 1 | - | 1 |
| Rivers Agency | - | - | 1 | - | 1 |
| Roads Service | 27 | 27 | 4 | - | 3 |
| Social Security Agency | 30 | 27 | 1 | 1 | 3 |
| **TOTAL** | **98** | **94** | **16** | **2** | **12** |

## Analysis of Written Complaints About Tribunals

| | Received | Determined at Complaint Validation Stage | Determined at Preliminary Investigation Stage | Determined at Detailed Investigation Stage | Ongoing at 31/03/13 |
|---|---|---|---|---|---|
| Appeals Service | - | - | - | 1 | - |
| Industrial Tribunal | 2 | 2 | - | - | - |
| Planning Appeals Commission | 2 | 2 | - | - | - |
| **TOTAL** | **4** | **4** | **-** | **1** | **-** |

## Analysis of Written Complaints About N/S Implementation Bodies

| | Received | Determined at Complaint Validation Stage | Determined at Preliminary Investigation Stage | Determined at Detailed Investigation Stage | Ongoing at 31/03/13 |
|---|---|---|---|---|---|
| Special European Union Programmes Body | - | 1 | - | - | - |
| **TOTAL** | **-** | **1** | **-** | **-** | **-** |

## Analysis of Written Complaints About Other Bodies

| | Received | Determined at Complaint Validation Stage | Determined at Preliminary Investigation Stage | Determined at Detailed Investigation Stage | Ongoing at 31/03/13 |
|---|---|---|---|---|---|
| Forensic Science NI | 1 | 1 | - | - | - |
| NI Authority for Utility Regulation | 1 | - | - | - | 1 |
| NI Courts & Tribunals Service | 6 | 7 | 1 | - | 1 |
| NI Prison Service | 9 | 7 | 3 | 1 | 2 |
| Planning Service* | 1* | 3 | 4 | - | 1 |
| **TOTAL** | **18** | **18** | **8** | **1** | **5** |

* Previous case which was reopened on comeback. Now recorded as DOE (P&LGG)

## Cases Determined – Analysis of Issues of Complaint

| Issue | Determined at Complaint Validation Stage | Determined at Preliminary Investigation Stage | Determined at Detailed Investigation Stage | Total |
|---|---|---|---|---|
| Complaints Handling | 15 | 4 | 3 | 22 |
| Delay | 10 | 1 | 3 | 14 |
| Enforcement / Legal Action | 8 | 5 | 3 | 16 |
| Other | 53 | 3 | 5 | 61 |
| Out of Jurisdiction | 4 | - | - | 4 |
| Policy and Procedures | 61 | 15 | 18 | 94 |
| Social Care and Treatment | 1 | - | - | 1 |
| Staff Attitude and Behaviour | 8 | - | - | 8 |
| **TOTAL** | **160** | **28** | **32** | **220** |

# SECTION 3

## Annual Report of the Northern Ireland Commissioner for Complaints

## (excluding Health and Social Care complaints)

My remit under the Commissioner for Complaints (NI) Order 1996 (the 1996 Order) extends to a wide range of public bodies in Northern Ireland. Under the 1996 Order, I investigate complaints about local councils, the Northern Ireland Housing Executive, Registered Housing Associations, Education and Justice bodies. The number of complaints made in this part of my jurisdiction has shown a small decrease overall (2%), which continues a trend noted in last year's Annual Report. The statistics demonstrate however that within this jurisdiction there are certain sectors where the figures have continued to rise. Complaints relating to health and social care bodies are investigated under the Commissioner for Complaints (Amendment) (NI) Order 1997 and are reported on separately in Section 4.

In my report last year I noted that the number of complaints about Registered Housing Associations continued to decrease. This year however there has been an increase in complaints about the Registered Housing Associations (45%). I have also received more complaints about the Housing Executive (28%). The issues of complaint are diverse and wide ranging. They include maintenance, anti-social behaviour, housing allocation and housing adaptations suitable to the needs of individual tenants and demonstrate in general an increasing dissatisfaction across the social housing sector. In previous reports I noted the effects of the continuing adverse economic climate on the provision of public services, where an increasing demand continues to develop and resources available to the public services continue to be constrained. The upward trend in complaints across the social housing sector is one indicator of the continuing pressure on the demand and related resources for social housing. In turn, the experiences of the citizen lead to an increase in complaints about the services delivered in this sector.

The number of complaints received about education authorities remains constant. However, the importance of the decisions taken in relation to the education provision, which can have a significant impact on the lives of our young people, was highlighted by a case which I recently reported on. In this instance I found maladministration against the Southern Education and Library Board (the Board) in relation to statements of special educational needs that it maintained on the twin sons of a complainant. I found that the Board did not take timely and appropriate action to finalise and issue amended statements of educational need and that there was delay in informing the parents of that error and resolving the mistake. I also found that the Board's handling of the parents' formal complaint was unsatisfactory; and that it failed to meet a specific undertaking, given by its Chief Executive, to provide additional support for the boys to help them prepare for their transition to post-primary education. I also criticised the Board because it did not, until the conclusion of my investigation, accept responsibility for these mistakes or acknowledge the impact of its actions on the boys and their parents. I recommended that the Chief Executive of the Board provide a written apology and a payment of £5,000 to the parents as redress for the injustice caused directly to them by the failings that I had identified. I also recommended that the Board make a further payment of £10,000 to the parents in order that they could arrange for additional help and support for the boys. I am pleased say that the Board accepted my findings and recommendations.

A recent complaint about an employment matter highlighted the importance of a public body dealing with its employees fairly and appropriately and responding to their complaints in a thorough and detailed manner. The complainant was an employee of the Northern Ireland Fire and Rescue Service (NIFRS) who alleged that documentation he had completed in support of a job evaluation process had been tampered with without his knowledge which lowered the final grading assigned to his post. The complainant believed that the matter had not been properly investigated by his employer. My investigation established a number of instances of maladministration by the NIFRS including an initial failure to undertake an investigation into the case, the perfunctory nature of the subsequent investigation, and delays in completing the investigation and responding to the complainant's correspondence. I concluded that the complainant was fully justified in bringing his complaint to me. I had no doubt that, as a result of maladministration by the NIFRS, the complainant experienced significant annoyance, frustration, additional stress, inconvenience and anger. By way of appropriate redress, I recommended that the complainant should receive a written apology from the Chief Executive of the NIFRS, along with a payment of £750. I am pleased to record that my recommendations were accepted.

The statistical information below reflects the number of complaints received in my Commissioner for Complaints role in 2012/13 and how they have been determined by my office. As noted on page 9, I have included a breakdown of

the 'Complainant Association' of written complaints received during the year. This is a new category, which relates to the complainant's relationship to the service provided by the Authority that they are complaining about.

## Written Complaints Received in 2012/13

A total of **182** complaints were received during 2012/13, 7 less than in 2011/12.

## Breakdown of Total Complaints

### Caseload for 2012/13

| | |
|---|---|
| Number of Written Complaints received | **182** |
| Number Determined at Complaint Validation Stage | **179** |
| Number Determined at Preliminary Investigation Stage | **33** |
| Number Determined at Detailed Investigation Stage | **16** |
| Number of Complaints / Investigations Ongoing at 31 March 2013 | **35** |

## Written Complaints Received in 2012/13 by Authority Type

| | |
|---|---|
| Local Councils – | **55** |
| Education Authorities – | **16** |
| Health and Social Care Bodies – (employment related issue) | **13** |
| Housing Authorities – | **16** |
| NI Housing Executive – | **59** |
| Other Bodies Within Jurisdiction – | **23** |

## Written Complaints Received in 2012/13 by Complainant Association

| | |
|---|---|
| Complainant – | **93** |
| Customer – | **2** |
| Employee – | **35** |
| Grant Applicant – | **4** |
| Job Applicant – | **1** |
| Tenant – | **47** |

# Recommendations in Cases Determined

| Case No | Body | Issue of Complaint | Recommendation |
|---|---|---|---|
| 13502 | NI Fire & Rescue Service | Complaint Handling | Apology; Payment of £750 |
| 13562 | Probation Board for NI | Complaint Handling | Action by body |
| 13614 | NI Housing Executive | Complaint Handling | Payment of £300 |
| 13932 | NI Housing Executive | Complaint Handling | Action by body |
| 201101088 | Larne Borough Council | Policies and Procedures | Apology; Payment of £100 |
| 201101053 | NI Housing Executive | Complaint Handling | Apology |
| 201101034 | Belfast Health & Social Care Trust | Policies and Procedures | Payment of £100 |
| 201100911 | Lisburn City Council | Policies and Procedures | Apology |
| 201100880 | NI Legal Services Commission | Complaint Handling | Apology |
| 201000752 | Belfast Health & Social Care Trust | Delay; Policies and Procedures | Apology; Payment of £500 |
| 201000454 | Northern Health & Social Care Trust | Policies and Procedures | Apology; Payment of £2,500 |
| 201000203 | Southern Education & Library Board | Policies and Procedures; Delay; Complaint Handling | Apology; Payment of £5,000; Financial redress of £10,000; Action by body |
| 200700225 | Armagh City & District Council | Policies and Procedures; Delay; Complaint Handling | Apology; Payment of £17,500; Financial redress of £28,363; Action by body |

# Statistical Information

## Analysis of Written Complaints Received in 2011/12

| | Received | Determined at Complaint Validation Stage | Determined at Preliminary Investigation Stage | Determined at Detailed Investigation Stage | Ongoing at 31/03/13 |
|---|---|---|---|---|---|
| Local Councils | 55 | 52 | 9 | 7 | 9 |
| Education Authorities | 16 | 14 | 1 | 1 | 5 |
| Health & Social Care Bodies | 13 | 12 | 5 | 5 | 7 |
| Housing Authorities | 16 | 14 | - | - | 2 |
| NI Housing Executive | 59 | 63 | 10 | 2 | 8 |
| Other Bodies Within Jurisdiction | 23 | 24 | 8 | 1 | 4 |
| **TOTAL** | **182** | **179** | **33** | **16** | **35** |

## Analysis of Written Complaints About Local Councils

| | Received | Determined at Complaint Validation Stage | Determined at Preliminary Investigation Stage | Determined at Detailed Investigation Stage | Ongoing at 31/03/13 |
|---|---|---|---|---|---|
| Antrim Borough Council | 2 | 2 | 1 | - | - |
| Ards Borough Council | 6 | 6 | - | - | - |
| Armagh City & District Council | 1 | 1 | - | 1 | - |
| Belfast City Council | 6 | 6 | - | - | - |
| Carrickfergus Borough Council | 4 | 4 | 2 | 2 | - |
| Castlereagh Borough Council | 2 | 2 | - | - | - |
| Cookstown District Council | 4 | 3 | - | - | 1 |
| Craigavon Borough Council | 5 | 4 | - | - | 1 |
| Derry City Council | 5 | 5 | 2 | - | 2 |
| Down District Council | 6 | 6 | - | - | - |
| Dungannon & South Tyrone Borough Council | 1 | 1 | - | - | - |
| Fermanagh District Council | 2 | 2 | - | - | - |
| Larne Borough Council | 3 | 2 | 1 | 1 | 2 |
| Lisburn City Council | 3 | 3 | 2 | 1 | 2 |
| Moyle District Council | 1 | 1 | - | - | - |
| Newry & Mourne District Council | 4 | 4 | - | - | 1 |
| Strabane District Council | - | - | 1 | 2 | - |
| **TOTAL** | **55** | **52** | **9** | **7** | **9** |

## Analysis of Written Complaints About Education Authorities

| | Received | Determined at Complaint Validation Stage | Determined at Preliminary Investigation Stage | Determined at Detailed Investigation Stage | Ongoing at 31/03/13 |
|---|---|---|---|---|---|
| Belfast Education & Library Board | 5 | 4 | - | - | 2 |
| North Eastern Education & Library Board | 2 | 2 | 1 | - | 1 |
| South Eastern Education & Library Board | 2 | 2 | - | - | - |
| Southern Education & Library Board | 6 | 5 | - | 1 | 2 |
| Western Education & Library Board | 1 | 1 | - | - | - |
| **TOTAL** | **16** | **14** | **1** | **1** | **5** |

## Analysis of Written Complaints About Health and Social Care Bodies

(where the complaint does not relate to health care)

| | Received | Determined at Complaint Validation Stage | Determined at Preliminary Investigation Stage | Determined at Detailed Investigation Stage | Ongoing at 31/03/13 |
|---|---|---|---|---|---|
| Belfast Health & Social Care Trust | 2 | 2 | 1 | 1 | 2 |
| Business Services Organisation | 1 | 1 | 2 | - | 2 |
| Northern Health & Social Care Trust | 1 | 2 | 2 | 3 | - |
| Public Health Agency | 1 | 1 | - | - | - |
| Regulation & Quality Improvement Authority | 1 | 1 | - | - | - |
| South Eastern Health & Social Care Trust | 3 | 3 | - | 1 | 1 |
| Southern Health & Social Care Trust | 1 | - | - | - | 1 |
| Western Health & Social Care Trust | 3 | 2 | - | - | 1 |
| **TOTAL** | **13** | **12** | **5** | **5** | **7** |

## Analysis of Written Complaints About Housing Authorities

| | Received | Determined at Complaint Validation Stage | Determined at Preliminary Investigation Stage | Determined at Detailed Investigation Stage | Ongoing at 31/03/13 |
|---|---|---|---|---|---|
| NI Housing Executive | 59 | 63 | 10 | 2 | 8 |
| Alpha Housing Association (NI) Ltd | 2 | 2 | - | - | - |
| Apex Housing | 1 | 1 | - | - | - |
| Clanmill Housing Association Ltd | 5 | 4 | - | - | 1 |
| Connswater Homes Ltd | 1 | 1 | - | - | - |
| Fold Housing Association | 1 | | - | - | 1 |
| Habinteg Housing Association (Ulster) Ltd | 2 | 2 | - | - | - |
| HELM Housing | 2 | 2 | - | - | - |
| Open Door Housing Association (NI) Ltd | 1 | 1 | - | - | - |
| Trinity Housing | 1 | 1 | - | - | - |
| **TOTAL** | **75** | **77** | **10** | **2** | **10** |

## Analysis of Written Complaints About Other Bodies Within Jurisdiction

| | Received | Determined at Complaint Validation Stage | Determined at Preliminary Investigation Stage | Determined at Detailed Investigation Stage | Ongoing at 31/03/13 |
|---|---|---|---|---|---|
| Arts Council | 1 | 1 | - | - | 1 |
| Equality Commission for NI | 4 | 4 | - | - | 1 |
| Health & Safety Executive | 3 | 3 | 2 | - | - |
| Invest NI | 1 | 1 | - | - | - |
| National Museums NI | 1 | 1 | - | - | - |
| NI Commissioner for Children & Young People | 2 | 2 | - | - | - |
| NI Fire & Rescue Service | 3 | 4 | 3 | 1 | - |
| NI Legal Services Commission | 1 | 1 | 1 | - | - |
| NI Police Fund | 1 | 1 | - | - | 1 |
| NI Policing Board | 1 | 1 | - | - | - |
| NI Social Care Council | 3 | 3 | 1 | - | 1 |
| Probation Board for NI | 2 | 2 | 1 | - | - |
| **TOTAL** | **23** | **24** | **8** | **1** | **4** |

## Cases Determined – Analysis of Issues of Complaint

| Issue | Determined at Complaint Validation Stage | Determined at Preliminary Investigation Stage | Determined at Detailed Investigation Stage | Total |
|---|---|---|---|---|
| Clinical Care and Treatment | - | 2 | - | 2 |
| Complaints Handling | 27 | 5 | 8 | 40 |
| Delay | 2 | 3 | - | 5 |
| Enforcement / Legal Action | 2 | - | 1 | 3 |
| Other | 57 | 4 | 1 | 62 |
| Out of Jurisdiction | 2 | - | 1 | 3 |
| Policy and Procedures | 38 | 13 | 10 | 61 |
| Staff Attitude and Behaviour | 4 | 1 | - | 5 |
| **TOTAL** | **132** | **28** | **21** | **181** |

# SECTION 4

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

Health and Social Care continues to represent a significant proportion of my Office's workload. Analysis of complaints received throughout the year shows an increase of 22% (45) in the number of cases received. A total of 237 cases dealt with within in the reporting period were concluded at the validation stage, which we aim to complete within 15 working days. Interestingly only a small number of complaints (2) relating to health and social care matters were 'out of jurisdiction', because I did not have the legal authority to deal with the matter complained of.

The main issue of complaint put to me for investigation continued to be clinical care and treatment, representing 37% (101) of the total number of issues of complaint received. The second most frequent issue of complaint was social care which accounted for 18% of the issues of complaint I received. Of note was the fact that 48 (17%) issues of complaint received were about complaints handling; a matter I cover extensively when speaking to public bodies in the health and social care system about the role of my Office.

In my annual report of 2010/11 I detailed some of the areas I cover with bodies in relation to common complaints handling failures that I have identified through my casework. This year I wish to add to what I said then by including the need to ensure that the methodology for any investigation undertaken as a result of a complaint is clearly explained to the complainant as early in the process as possible. I also wish to highlight that whilst I fully appreciate the need for a proportionate investigative approach in relation to a complaint, it is generally unacceptable for a complainant, who has gone to the effort of raising a formal complaint, to receive a response which, the content of has been largely, if not in its entirety, compiled by the person complained about. I recognise the need for any individual complained of to give an account of their actions; this is in fact a fundamental of any good investigation, however, this should be coupled with appropriate analysis and critique on a clinical or professional level, and a corporate level to ensure a robust investigation of any concerns raised.

In my 2010/11 report I also reminded bodies of the need to think holistically about cases, especially in health and social care where a number of services and therefore professionals had been involved in a case. In making this point I was primarily referring to cases which spanned a number of services/ professionals within the same Trust, for example. This year I wish to highlight the need to ensure that complaints involving more than one Trust or for example a Trust and a General Practice should be dealt with in a co-ordinated manner and where possible the opportunity for joint investigation and response should be utilised. The Department of Health, Social Services and Public Safety's document 'Complaints in Health and Social Care, Standards and Guidelines for Resolution makes clear that in cases where 'joint complaints' are received, that is a complaint relates to the actions of more than one HSC organisation, there is a need for co-operation and partnership between the relevant organisations in agreeing how best to approach the investigation and resolution of the complaint. The document goes on to state that 'It is possible that the various aspects of the complaint can be divided easily with each organisation able to respond to its own area of responsibility. The complainant must be kept informed and provided with advice about how each aspect of their complaint will be dealt with and by whom.' Unfortunately, in some of the cases I have seen, especially those involving independent contractors such as General Practitioners little or no consideration appears to be given to co-operation and partnership working between the relevant organisations. This undoubtedly creates an unsatisfactory situation for complainants who in some instances are being given one explanation for an incident or sequence of events from one organisation only to have this contradicted and undermined by the response they receive from another organisation.

My experience in dealing with complainants who have cause to complain about health and social care is that they quite rightly view health and social care as one system. They do not see it as a series of bodies or contractors with whom they are required to deal with separately. Their experiences of health and social care happen to them as a continuum, therefore any complaint they make should, in my view, be dealt with in a way that recognises this. I am therefore stressing to Health and Social Care bodies that in circumstances where joint complaints about health and social care are submitted that proper consideration should be given to considering the complaint in a co-ordinated way and responding to the complainant in a seamless and integrated way.

The health and social care case summaries presented in this report reflect the range of casework I have completed within the period 2012/13. These show the diversity of the issues complained of and often the complex clinical scenarios which complainants find themselves in. I

remain convinced that even in circumstances where I have not upheld a complaint of maladministration, relating to poor clinical care and treatment or diagnosis, the emphasis and focus placed by my office in providing an improved and more accessible explanation and understanding of events is sometimes enough to address the complainant's concerns. I continue to emphasise, through my outreach work, the need for bodies in jurisdiction to ensure that in responding to complainants 'a complainant centred approach' is adopted. Such an approach can help to ensure that complaints are not always progressed to the next level purely because information has been communicated poorly or in a style which assumes a degree of corporate, clinical or professional knowledge on the part of the complainant; something which the majority of complainants would not nor should not be expected to possess.

The statistics below reflect the numbers of health and social care complaints received during 2012/13 and how they have been determined by my office. As noted on page 9, I have included a breakdown of the 'Complainant Association' of written complaints received during the year. This is a new category, which relates to the complainant's relationship to the service provided by the Authority that they are complaining about.

## Written Complaints Received in 2012/13

A total of **253** complaints were received during 2012/13, 45 more than in 2011/12.



## Breakdown of Total Complaints

### Caseload for 2012/13

| | |
|---|---|
| Number of Written Complaints received | **253** |
| Number Determined at Complaint Validation Stage | **237** |
| Number Determined at Preliminary Investigation Stage | **69** |
| Number Determined at Detailed Investigation Stage | **31** |
| Number of Complaints / Investigations Ongoing at 31 March 2013 | **71** |

## Written Complaints Received in 2012/13 by Authority Type

| | |
|---|---|
| Health & Social Services Boards – | **6** |
| Health & Social Care Trusts – | **191** |
| Other Health & Social Services Bodies – | **56** |

## Written Complaints Received in 2012/13 by Complainant Association

| | |
|---|---|
| Complainant – | **142** |
| Patient – | **67** |
| Social Care Client – | **44** |

# Recommendations in Cases Determined

| Case No | Body | Issue of Complaint | Recommendation |
|---|---|---|---|
| 13191 | Southern Health & Social Care Trust | Clinical Care and Treatment | Apology;<br>Payment of £1,000 |
| 13434 | Western Health & Social Care Trust | Clinical Care and Treatment | Apology |
| 13690 | Health Service Providers (GP) | Complaint Handling | Settled – local resolution |
| 13701 | Belfast Health & Social Care Trust | Complaint Handling | Apology;<br>Payment of £100 |
| 201100922 | South Eastern Health & Social Care Trust | Policies and Procedures | Apology;<br>Review of Process;<br>Payment of £1,000 |
| 201100882 | Regional Health & Social Care Board | Complaint Handling | Apology;<br>Review of Process |
| 201100868 | Belfast Health & Social Care Trust | Delay | Apology;<br>Payment of £500 |
| 201100834 | Western Health & Social Care Trust | Policies and Procedures | Apology;<br>Review of Process |
| 201100777 | Western Health & Social Care Trust | Complaint Handling | Apology |
| 201100401 | Belfast Health & Social Care Trust | Policies and Procedures;<br>Staff Attitude and Behaviour | Apology;<br>Action by body |
| 201100279 | South Eastern Health & Social Care Trust | Clinical Care and Treatment;<br>Complaint Handling | Payment of £1,000;<br>Action by body |
| 201100278 | Belfast Health & Social Care Trust | Clinical Care and Treatment;<br>Complaint Handling | Payment of £1,000;<br>Action by body |
| 201001220 | Northern Health & Social Care Trust | Complaint Handling;<br>Policies and Procedures | Apology;<br>Payment of £250 |
| 201000981 | South Eastern Health & Social Care Trust | Policies and Procedures;<br>Delay | Apology;<br>Payment of £300 |
| 201000769 | Northern Health & Social Care Trust | Clinical Care and Treatment | Apology |
| 201000115 | Health Service Providers (GP) | Complaint Handling;<br>Clinical Care and Treatment | Apology;<br>Payment of £2,000 |
| 201000057 | Health Service Providers (GP) | Policies and Procedures;<br>Complaint Handling | Apology;<br>Payment of £500 |

| Case No | Body | Issue of Complaint | Recommendation |
|---|---|---|---|
| 200900787 | South Eastern Health & Social Care Trust | Clinical Care and Treatment | Apology;<br>Payment of £5,000;<br>Action by body |
| 200900766 | Belfast Health & Social Care Trust | Clinical Care and Treatment;<br>Complaint Handling | Apology;<br>Payment of £4,000;<br>Action by body |
| 200900242 | South Eastern Health & Social Care Trust | Clinical Care and Treatment | Apology;<br>Payment of £5,000 |
| 200900240 | Belfast Health & Social Care Trust | Clinical Care and Treatment | Apology;<br>Payment of £20,000 |
| 200700737 | Northern Health & Social Care Trust | Staff Attitude and Behaviour | Apology;<br>Payment of £3,000 |
| HC035/04 | Western Health & Social Care Trust | Clinical Care and Treatment;<br>Policies and Procedures;<br>Complaint Handling | Apology;<br>Payment of £3,000 |

# Statistical Information



## Analysis of Written Complaints Received in 2012/13

| | Received | Determined at Complaint Validation Stage | Determined at Preliminary Investigation Stage | Determined at Detailed Investigation Stage | Ongoing at 31/03/13 |
|---|---|---|---|---|---|
| Health & Social Care Trusts | 191 | 183 | 60 | 21 | 52 |
| Health & Social Services Boards | 6 | 6 | - | 1 | 2 |
| Other Health & Social Services Bodies | 56 | 48 | 9 | 9 | 17 |
| **TOTAL** | **253** | **237** | **69** | **31** | **71** |

## Analysis of Written Complaints About Health & Social Services Boards

| | Received | Determined at Complaint Validation Stage | Determined at Preliminary Investigation Stage | Determined at Detailed Investigation Stage | Ongoing at 31/03/13 |
|---|---|---|---|---|---|
| Regional Health & Social Care Board | 6 | 6 | - | 1 | 2 |
| **TOTAL** | **6** | **6** | **-** | **1** | **2** |

## Analysis of Written Complaints About Health & Social Care Trusts

| | Received | Determined at Complaint Validation Stage | Determined at Preliminary Investigation Stage | Determined at Detailed Investigation Stage | Ongoing at 31/03/13 |
|---|---|---|---|---|---|
| Belfast Health & Social Care Trust | 53 | 51 | 15 | 6 | 17 |
| Northern Health & Social Care Trust | 37 | 33 | 11 | 3 | 10 |
| Northern Ireland Ambulance Service Trust | 3 | 2 | 2 | 1 | 2 |
| South Eastern Health & Social Care Trust | 23 | 24 | 9 | 5 | 7 |
| South Eastern Health & Social Care Trust (Prison Healthcare) | 11 | 11 | 1 | - | - |
| Southern Health & Social Care Trust | 26 | 25 | 13 | 3 | 8 |
| Western Health & Social Care Trust | 38 | 37 | 9 | 3 | 8 |
| **TOTAL** | **191** | **183** | **60** | **21** | **52** |

## Analysis of Written Complaints About Other Health and Social Services Bodies

| | Received | Determined at Complaint Validation Stage | Determined at Preliminary Investigation Stage | Determined at Detailed Investigation Stage | Ongoing at 31/03/13 |
|---|---|---|---|---|---|
| Business Services Organisation | 3 | 2 | - | - | 1 |
| Health Service Providers (GDP) | 9 | 9 | 4 | 5 | 1 |
| Health Service Providers (GP) | 32 | 27 | 4 | 4 | 11 |
| Independent HSC Provider | 3 | 1 | - | - | 2 |
| Independent HSC Provider (Out of Hours GP Services) | 1 | - | - | - | 1 |
| Independent HSC Provider (Private Nursing Home) | 3 | 2 | 1 | - | 1 |
| Regulation & Quality Improvement Authority | 2 | 4 | - | - | - |
| Not Specified Body | 3 | 3 | - | - | - |
| **TOTAL** | **56** | **48** | **9** | **9** | **17** |

## Cases Determined – Analysis of Issues of Complaint

| Issue | Determined at Complaint Validation Stage | Determined at Preliminary Investigation Stage | Determined at Detailed Investigation Stage | Total |
|---|---|---|---|---|
| Clinical Care and Treatment | 64 | 29 | 8 | **101** |
| Complaints Handling | 17 | 16 | 15 | **48** |
| Delay | 11 | 1 | 1 | **13** |
| Other | 9 | 4 | 1 | **14** |
| Out of Jurisdiction | 2 | - | - | **2** |
| Policy and Procedures | 14 | 13 | 3 | **30** |
| Social Care and Treatment | 33 | 4 | 13 | **50** |
| Staff Attitude and Behaviour | 11 | 4 | 2 | **17** |
| **TOTAL** | **161** | **71** | **43** | **275** |

# APPENDIX A

## Selected Case Summaries

**Assembly Ombudsman for Northern Ireland and Northern Ireland Commissioner for Complaints (including Health and Social Care Complaints)**

Appendix A

# Assembly Ombudsman for Northern Ireland – Selected Summaries of Investigations

## Department of Education – Education and Training Inspectorate

### Information Retention and Destruction of Records

The complainant in this case complained about the actions of the Education and Training Inspectorate (ETI). In particular, she complained that ETI failed to recognise her complaint; that it had destroyed the evidence base of a follow-up school inspection it had undertaken; and that the reporting system used for that inspection had several inaccuracies.

My investigation found evidence of maladministration on the part of ETI in relation to the premature destruction of the evidence base of the follow-up school inspection. I was satisfied that this action meant that the complainant was effectively denied her fundamental right to challenge and question the detail of the matters which gave rise to the criticism. This practice also failed to take account of the need to respond to any enquiries that I or any other party might make in the event that the complainant challenged or queried ETI's actions beyond the scope of its own internal complaints process. I also identified maladministration in the ETI's complaints handling processes, although I was satisfied that the complainant did not sustain an injustice as a consequence of that failing. The practice had already ceased at the time of my investigation.

I recommended that the follow-up inspection report should be withdrawn as it could not be relied upon. The Permanent Secretary of the Department of Education accepted the findings of my investigation and my recommendation. The ETI has also taken practical measures to improve its complaints handling processes. **(201100820)**

## Department of Justice

### Administration of the Police Part-Time Reserve Gratuity Scheme

The complainant in this case was a former member of the Police Part-Time Reserve. He complained about the actions of the Department of Justice (the Department) in relation to its administration of the Police Part-Time Reserve Gratuity Scheme (the Scheme).

The complainant complained that the Department, in refusing to process his application for a payment from the Scheme, which he submitted approximately three months after the closing date, had treated him unfairly and inequitably and, effectively, refused to recognise his 20 years' service with the Part Time Reserve. He was aggrieved that the Department opted to conduct a media campaign to bring the Scheme to the attention of potential applicants rather than contacting each individual personally, which he considered resulted in him being unaware of the Scheme until well after the deadline for the receipt of applications. He contended that the media campaign was ineffective, and that the Department failed to recognise this by extending the closing date. He also complained about the Department's handling of his appeal against the declination of his application and its handling of a formal complaint he made to it about its actions.

I upheld only one aspect of the complaint, that is, with regard to the Department's handling of the complainant's appeal. I found that the Department had provided him with misleading information about the remit of the Scheme's appeal procedure, and that there was also an unacceptable delay in notifying him of the outcome of his appeal. In addition, I was critical of the unsatisfactory administration by the Department of the formal complaint the complainant had submitted to it about its actions. However, I have concluded that this did not cause the complainant to sustain an injustice.

I found no evidence of maladministration by the Department in relation to any of the other elements of the complaint. **(201100483)**

## Department of the Environment Planning Service

### Processing of Planning Application

This complaint related to the handling of an application to demolish the existing rear extension of a neighbouring property and the erection of a two storey extension. When implemented, the complainant believed that the extension would dominate and partially overshadow his home.

My investigation sought to establish whether there was evidence of maladministration on the part of the Department of the Environment Planning Service (PS) in its actual processing of the planning application in question and/or its dealings with the complainant, as a result of which he suffered an injustice.

My investigation revealed administrative failings on the part of PS in its handling of the planning application, namely:

- Lack of written evidence that provided an insight into the deliberations of the case officer with regard to the effect or otherwise the development may or may not have on the complainant's property;
- An incomplete record of the Development Control Group meeting at which the planning application was agreed;
- Failure to record receipt and consideration of two letters of objection from the complainant;
- Lack of response to a specific query raised by the complainant in a letter of objection.

I was critical of the PS for these failings, which I found to constitute maladministration. However, despite these particular failings and even when one considered them cumulatively, I was satisfied that they did not adversely effect the final determination of the planning application.

I was however satisfied that the complainant sustained an injustice as he had the anxiety, frustration, worry and uncertainty suffered as a result of his experience with the PS in relation to the decision making process. I recommended that the Acting Deputy Secretary of the Department of the Environment issue a letter of apology to the complainant together with a payment of £500. I am pleased to record that my recommendation was accepted. **(201000885)**

### Application for Retrospective Planning Approval

This complaint concerned the handling of an application for retrospective planning approval by the Department of the Environment Planning Service (PS) for the retention of a home working taxi business.

I sought to establish whether there was evidence of maladministration on the part of the PS in its actual processing of the planning application in question and/or its dealings with the complainant, as a result of which he suffered an injustice. My investigation disclosed the following failings on the part of the PS in its administration of the planning application:

- incorrect fee recorded in error;
- a confusing and unhelpful letter;
- inaction resulting in unacceptable delay;
- incorrect date on letter.

I found these failings to constitute maladministration and that the complainant had suffered an injustice. However, despite these individual failings and even when considered cumulatively, I was satisfied that they did not adversely affect the determination of the planning application. In recognition of the maladministration and injustice which I identified, I recommended that the Acting Deputy Secretary of the Department of the Environment make financial redress of £1,500 to remedy the injustice sustained by to the complainant. I am pleased to record that my recommendation was accepted. **(201100463)**

### Handling of Planning Application

This complaint concerned the handling of two planning applications both for the demolition of an existing dwelling to facilitate 4 apartments with associated parking.

The complainant explained that planning application for the demolition of an existing dwelling to facilitate 4 apartments with associated parking was recommended by the Department of the Environment Planning Service (PS) as a refusal. However, the application was withdrawn by the applicant prior to a decision being issued. The complainant advised that a further planning application for the same development, with minor amendments, was submitted and granted planning permission. The complainant believed that this demonstrated an inconsistent and contradictory approach by the PS.

I found that the second application could not be termed the "same" as the first application as there were differences in height, landscaping, location of bedrooms and kitchen/living areas and removal of 1st floor rear balconies. Unless the circumstances of each application are identical, there can be no automatic read across. I was satisfied that the applications referred to by the complainant could not be regarded as identical applications and, as such, they could not be considered as evidence in demonstrating an inconsistent and contradictory approach by PS in dealing with his objections. I did, therefore, seek to establish whether there was evidence of maladministration on the part of the PS in its actual processing of the planning application which was granted planning permission.

Overall, from the information available to me, I did not identify any improper consideration on the part of PS in its handling of the planning application. In the circumstances I found no reason to challenge the final decision to grant approval. **(201100468)**

## Application for Development of Land

This complaint concerned the processing of a planning application for the development of land adjacent to the complainant's home.

In considering the complaint, I identified several issues which I summarised under the heading "Process unnecessarily confusing and lacking in clarity". I sought to establish whether there was evidence of maladministration on the part of the Department of the Environment Planning Service (PS) in its actual processing of the planning application in question and/or its dealings with the complainant, as a result of which she suffered an injustice. My investigation revealed failures, on more than one occasion, in replying to the complainant's correspondence.

I criticised the PS for these failings, which I found to constitute maladministration. However, despite these individual failings, I was satisfied that they did not adversely effect the determination of the planning application. In recognition of the maladministration and injustice which I identified throughout my investigation, I recommended that the Acting Deputy Secretary of the Department of the Environment make a payment of £250 to the complainant. I am pleased to record that my recommendation was accepted. **(201100507)**

## Planning Application for a Pigeon Loft

The complainants in this case alleged the mishandling of a planning application for a pigeon loft at a neighbouring property.

In considering the complaint, I sought to establish whether there was evidence of maladministration on the part of the Planning Service (PS) in its actual processing of the planning application in question and/or its dealings with the complainants, as a result of which they suffered an injustice. From my investigation of the information available to me, I found no evidence of maladministration on the part of the PS. **(201100633)**

## Location of Foul Water Tanks

The complainant resided in the countryside, within a cluster of neighbouring dwellings. His neighbour obtained planning permission (without objection) to install two underground tanks for the collection of foul water from a farm yard. However, the complainant believed the tanks had been installed at an incorrect location which was in contravention of the approved plans. After utilising the Department of the Environment Planning Service (PS) internal complaints process, the complainant raised the matter with my Office.

I found that, using the Freedom of Information Act, an MLA had obtained copies of the contents of relevant enforcement files from PS on behalf of the complainant. The documents included maps which the complainant mistakenly believed indicated the approved location for the installation of the tanks. My investigation identified the actual approved plans and from these I was satisfied that the tanks had in fact been installed at the approved location. I therefore did not uphold this complaint.

Although it did not form part of the complaint, I was dissatisfied with the level of detail I found in the PS file record which recorded the decision-making process in this case. The extent of the case officer's consideration of the planning application was recorded as follows:

"The proposal is acceptable. There will be no adverse impacts. There are no objections. I recommend approval."

The Development Control Group, which included two other senior planners added the following details to the Department's consideration of the planning application: -

"Agree with recommendation."

While I acknowledged that none of the neighbours to the site objected to the planning application, I nonetheless viewed the level of detail in the case report to be inadequate. Given the proximity of neighbouring dwellings, in my opinion, at the very least, comment should have been made in the report about why it was considered that any effect on the amenity of neighbours would not be so substantial as to justify refusal of the application.

In the circumstances, I expressed my dissatisfaction to the Acting Deputy Secretary of the Department of the Environment about the level of detail that had been recorded in the planning records relating to this case and I record that he has fully accepted my findings. This is an aspect of the planning process that I continue to monitor via the complaints which I receive. **(201101124)**

## Land and Property Services

### Delay in Valuation of Property

The complainant in this case told me that he contacted the Land and Property Service (LPS) in 2004 seeking an estimate / valuation for a property; however, the valuation was not undertaken until 2006, and the owners of the property did not receive a rates demand until 2011. I noted that it also took a further year for LPS to contact the complainant.

From the evidence available, it was clear that there had been significant maladministration in LPS's handling of this rates account. In particular, the lengthy delay in having the property valued and subsequent issuing of the appropriate rates bill. LPS had already acknowledged the errors that had occurred, and made a proposal that the rates arrears could be paid off over an extended period. LPS wrote off 25% of the arrears and in light of this and the extension given for the repayment of the rates arrears, I concluded that my investigation could not achieve any better outcome for the complainant than LPS had already proposed. **(13636)**

### Rating of Homes

The complainant in this case told me that he had applied for exclusion of rates under the Rating of Empty Homes legislation which was introduced on 1 October 2011. At that time, the Land and Property Services (LPS) advised him that his application had been successful and that his property would not be liable for rates until 31 March 2013. However, the complainant was informed some nine months later that his application for exclusion was ineligible and that he faced an outstanding rates bill.

In my examination of this case it was clear that there had been significant errors in LPS's handling of the complainant's rates account. In particular, inaccurate information had been given to him in relation to the exclusion under the Rating of Empty Homes legislation. Whilst I have no authority to set aside the requirement of LPS to seek payment of outstanding rates, I did however ask that a review of the case be carried out by LPS. Having reviewed the case, LPS agreed to offer a payment of £200 to the complainant by way of remedy in recognition of the inconvenience and frustration he had been caused. LPS also agreed to offer an extended payment arrangement to the complainant. I was pleased to note this acceptance of responsibility by LPS and considered it to be a satisfactory remedy for the injustice caused by the maladministration identified. **(13647)**

### Poor Service

The complainant in this case was a property developer who owned a vacant property, which he intended to renovate or redevelop. A change in rating law introduced a liability for rates with regard to vacant properties. The Land and Property Services (LPS) informed the complainant of the liability in advance of the new rules coming into effect and a rates bill was issued.

However, despite requesting that the bill be sent to the complainant's home address, LPS sent the bill to the address of the vacant property, which caused delay in the receipt of the bill. When the complainant eventually discovered the bill, he requested that LPS carry out a valuation of the dwelling because he believed it was 'incapable of beneficial occupation'. Where such a determination is made, 'vacant' rates are not payable. After 7 weeks, the complainant

contacted LPS and discovered that his request had not been initiated. He made the request again. Several months later, a valuation established that the dwelling was in fact capable of beneficial occupation.

Two months later the dwelling was valued again after the demolition of one of its walls. This time the dwelling was found not to be capable of beneficial occupation, and so, from that point, 'vacant' rates were no longer payable in respect of the property.

Before my Office became involved, the LPS acknowledged that the complainant had experienced a poor service, and the Chief Executive (CE) issued a written apology. However, the complainant came to me because he believed that, but for the poor service, a valuation would have been carried out on the dwelling sooner, thereby effectively enabling him to take action to either render the dwelling incapable of beneficial occupation (by commencing re-development) or let the dwelling, after renovating the kitchen and bathroom.

At the outset, I acknowledged that the poor service experienced by the complainant had constituted maladministration, which had caused an injustice in terms of the frustration and annoyance sustained by the complainant.

However, after careful consideration, I was satisfied that the complainant had the choice to either begin the process of re-development, or let the dwelling, irrespective of the timing of the valuation. The key information that the complainant had received from LPS was that he would become liable for the rates of the vacant property. In my opinion, by not exercising one of the options described above sooner, the complainant caused himself to become liable for the rates on the vacant property until he eventually chose to begin re-development work by demolishing a wall.

However, in recognition of the injustice of annoyance and frustration caused to the complainant by the maladministration represented by poor service, I recommended that LPS should make a payment of £200 to him in addition to the written apology previously offered. I am pleased to record that the CE of LPS accepted my recommendation. **(13708)**

## Compensation Services

### Policy and Procedures

In this case, the complainant instructed her solicitor to pursue a criminal injury complaint on behalf of her daughter who had been bitten by a dog. Subsequently, her application for criminal injury compensation was refused on the grounds that the incident did not constitute a criminal injury. Having asked for a review, the Compensation Agency (the Agency) offered compensation, which the complainant accepted. The complainant advised that she instructed the Agency that her solicitor's fees were to be paid out of the award.

My investigation identified that the Agency holds in trust any award made to a minor applicant until such times as the applicant attains his or her majority, and that the Agency only authorises payment out of trust funds where it is deemed reasonable in all the circumstances to do so. In this case, the Agency agreed to the payment of legal costs relevant to the scales set out in the Criminal Injuries (Compensation) (Northern Ireland) Order 1988 but not at the level requested by the complainant's solicitor.

My investigation did not identify any evidence of maladministration, and I was satisfied that the Agency had complied with its policy in this regard. **(13331)**

# Northern Ireland Commissioner for Complaints – Selected Summaries of Investigations



## Antrim Borough Council

### Damage to Household Bin

This complainant in this case advised that Antrim Borough Council's (the Council) refuse collectors damaged his black wheelie bin, causing an 18 inch split down the front of it. The complainant was dissatisfied with the Council's refusal, following an inspection of the bin, to make good the damage or to pay for a replacement bin. The complainant said the Council subsequently informed him that black bins are supplied with a 5-year warranty against manufacturer's defects and, as his bin was 8 years old, and therefore out of warranty, there were no grounds on which it should be replaced at the Council's expense.

The complainant said he was not informed by the Council, prior to reporting the damage, of any 5-year guarantee period that applied to the bin. The complainant considered that the Council relied on the manufacturer's guarantee period as a means of avoiding its responsibilities when damage is caused by its staff. Also, the complainant considered that the Council should have made this policy clear to its ratepayers, when it provided bins to householders or subsequently when the Council formulated its relevant policy.

My investigation of this complaint established that plastic wheeled bins are subject to deterioration and that, over time, they become brittle due to the oil content in the plastic drying out. My investigation also established that the Council's bins are guaranteed by the manufacturer for a period of 5 years. In the event that a plastic wheeled bin, which is less than 5 years old, is damaged in the course of the waste collection process, it is the Council's policy to replace the bin free of charge to the householder concerned. However, under its policy, the Council will not provide its ratepayers with replacement bins, free of charge, in circumstances where a damaged bin is more than 5 years old and where the Council's bin lifting equipment was not responsible for that damage. My investigation established that the Council's relevant policy affords it no discretion in this matter.

The Council confirmed to me that it had not informed its ratepayers of its policy in relation to the application of the 5-year warranty period, which is a key factor in its determining whether or not replacement bins should be provided at no cost to the householder concerned. However, the Council's Chief Executive (the CE) told me that the Council was "happy to take this point on board". In these circumstances, I asked the CE to review the wording of the relevant Council policy and any other information available to its ratepayers, to include specific reference to this aspect of the policy.

I was pleased to record that the CE fully agreed to my request. Following the review, the CE informed me that the Council had undertaken a range of measures to ensure that its relevant policy, and in particular the warranty period, was well communicated. These measures included the policy being available on the Council's website, the warranty period being highlighted and communicated to ratepayers at the point of sale, and the inclusion of information on the warranty period on the sale receipt. **(13404)**

## Health & Safety Executive

### Enforcement / Legal Action

This complaint related to the enforcement action taken by the Health and Safety Executive (HSE) following a building site accident involving equipment owned by the complainant. The complainant was unhappy with the investigation carried out by the HSE and felt that misleading information had been forwarded to the Public Prosecution Service (Northern Ireland).

My investigation did not identify any maladministration by the HSE in its decision to take enforcement action against the complainant. I also concluded that the matters raised by the complainant in relation to the cause of the incident had been properly dealt with by the courts and that the complainant had the appropriate opportunity to have his concerns heard during the court proceedings. **(13276)**

## Northern Health & Social Care Trust

### Handling of Tender

The complainant, who owned a taxi business, submitted a bid in respect of a tender for the provision of taxi services which the Trust had advertised. However, the complainant's bid was excluded by the Trust because his business was deemed not to be financially viable, one of the pre-requisites of the tender competition. The complainant was dissatisfied because a competitor, whom he considered to be in financial difficulties, was subsequently awarded a contract as part of the same tender process.

I found that the Trust's preferred means of determining whether a bidder was financially viable was by reference to a company which compiled statistical information on businesses. However, this method was only possible if the bidder happened to be registered with that company. Where a bidder was not registered, and in order to be inclusive, the Trust determined whether the financial viability pre-requisite had been met by scrutinising the bidder's accounts.

With regard to those bidders who had the relevant registration, I found that (having established there to be a ready pool of taxi providers, and being aware that the risk of financial loss to the Trust was low) the Trust determined that those bidders who were deemed (from the statistical analysis) to have "a high risk of business failure" would be considered to be financially viable for the purposes of the tender. The complainant's competitor fell into this category.

My investigation concluded that the complainant had been unfairly excluded from the tender and that this constituted maladministration. I also found that had the complainant not been excluded, he would have been offered a contract with the Trust. That being so I found that the complainant experienced an injustice.

By way of remedy, I recommended that the Chief Executive should provide the complainant with a written apology and that a payment of £2,500 should be made. The Trust accepted my recommendations. **(201000454)**

## Northern Ireland Fire & Rescue Service

### Amendment to Job Description

The complainant in this case, an employee of the Northern Ireland Fire and Rescue Service (NIFRS), discovered in 2011 that changes had been made, without his knowledge, to the job description he had completed in 2005 to enable his post in the NIFRS to be subject to a Job Evaluation process. The interference with the complainant's job description caused the complainant a detriment in terms as a result of the grading of his post. While the cause of the detriment was remedied in 2011 when the complainant's post was upgraded, the complainant considered it necessary to complain to me about his dissatisfaction with the actions taken by the NIFRS in 2011, when it learned that the complainant's job description had been changed. The complainant was also dissatisfied with the outcome of an investigation by the NIFRS into this matter. In this regard, although the NIFRS concluded, as a result of its investigation, that the complainant's job description had "undoubtedly been altered", it was unable to ascertain how this may have happened or who had been responsible.

My investigation of this complaint established a number of instances of maladministration by the NIFRS relating to:

- its failure to undertake an investigation into this case;
- the extent of its investigation process, which I considered to have been perfunctory and to have fallen very short of thorough;
- its failure to adequately inform the complainant concerning the investigation;
- its timescale and when the complainant would be notified of the outcome; and
- its failure, during a period of 17 weeks, to respond to correspondence from the complainant at a time when he was already experiencing stress and was seeking an assurance from the NIFRS that it had a genuine regard for his welfare.

I had no doubt that, as a result of maladministration by the NIFRS, the complainant experienced the injustice of significant annoyance, frustration, additional stress, inconvenience and anger. By way of appropriate redress, I recommended that the complainant should receive a written apology from

the Chief Executive (CE) of the NIFRS, along with a payment of the sum of £750 from the NIFRS. I am pleased to record that the CE accepted my recommendations. **(13502)**

## Northern Ireland Housing Executive

### Handling of Complaint

I received a complaint seeking an investigation into maladministration on the part of the Northern Ireland Housing Executive (NIHE). It related to a complaint made to the NIHE about substandard work, which was being carried out to the complainant's property at that time.

The complainant stated that the NIHE had chosen to ignore the complaint about the unsatisfactory work carried out to her property as part of the Group Repair Scheme, and the failure of the NIHE to follow its own procedures for dealing with complaints. The complainant also stated that, had her complaint not been 'ignored' by the NIHE, she would not have had to initiate legal proceedings. Following the conclusion of the legal action, the complainant wrote to the Chief Executive of the NIHE asking for her original complaint to be investigated and requesting compensation for costs incurred in repairing damage to her property as well as the costs incurred as a result of her having to initiate legal proceedings.

I found no evidence that the complaint was 'ignored' by the NIHE. In fact, I established that the complaint was addressed by NIHE by forwarding it to the contractors. However, on the basis of the information obtained during this investigation, I made finding of maladministration against the NIHE for the following:

- failing to act in accordance with its own complaints procedure;
- for not adequately communicating with the complainant during the handling of her 'correspondence',
- for failing to monitor the outcome of the referral to the Contractor in co-ordinating a response to address the complainant's concerns; and
- for failing to keep proper and appropriate records.

Whilst I found that the complainant sustained an injustice as she did not have her complaint dealt with adequately in line with the NIHE procedures, when considering an appropriate remedy, I also had to take into account whether the actions of the complainant or third party caused or contributed to an injustice. The complaint to the NIHE concerned substandard works to the complainant's property, which was the fault of the builder and which was subsequently remedied by way of court proceedings. In this case, the complainant also complained about the NIHE's failure to properly deal with her complaint. I upheld this aspect of the complaint and recommended that an apology should be issued to the complainant. The NIHE accepted my recommendation and also provided assurance that there are now adequate contract management procedures in place to deal with complaints about Group Repair Schemes. **(201101053)**

Appendix A

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

## Belfast Health and Social Care Trust

### Alleged Misdiagnosis

The complainant asked me to investigate a complaint he had made against the Belfast Health and Social Care Trust (the Trust) relating to the care and treatment provided to his late wife by the Mater Infirmorium Hospital and the Belfast City Hospital.

The complainant's wife was diagnosed with colorectal cancer following a routine appendectomy and underwent a hemicolectomy and subsequent chemotherapy treatment. Sadly, she passed away. The complainant had many concerns about the care provided to his wife, both in respect of the treatment she received, and communication with them both about her prognosis.

The complainant submitted a complaint to the Trust, however following a meeting, he remained dissatisfied with the Trusts response and he submitted his complaint to my Office.

I carefully examined all of the evidence obtained during my investigation, including extensive advice received from my three Independent Professional Advisors. I found that the complainant had suffered injustice as a result of maladministration by the Trust as a consequence of the following:

its failure to meet the Royal College of Surgeons 'Good Medical Practice Guidelines 2002' and the General Medical Council 'Guidelines on Good Medical Practice' in respect of record keeping responsibilities; and

its failure to meet the Department of Health, Social Services and Public Safety's 'Complaints in Health and Social Care, Standards and Guidelines for Resolution and Learning' in the handling of the complaint.

I also found that there was an avoidable delay in the 'timeline' of the care and treatment between the cancer diagnosis and the hemicolectomy due to a delay in the reporting of the CT scans. Whilst I found this to constitute maladministration, as there is no firm evidential basis upon which to assess the negative impact due to one month delay in surgery, I was unable to conclude whether the delay in the hemicolectomy had any adverse impact on the complainant's wife's subsequent treatment or prognosis.

I recommended that the Trust provided the complainant with a full written apology for the failings I identified, and a payment of £4,000 in recognition of: the distress, time and trouble caused to the complainant in having to pursue his complaint in order to obtain answers that should have been readily available to him earlier in the process; and the uncertainty which remains in respect of those areas affected by poor record keeping. I also made a number of recommendations to the Trust in relation to communication, record keeping, and complaints handling. I am pleased to note that the Trust accepted my recommendations.

I was reassured that the Trust had already identified and initiated a number of service improvements as a result of this complaint. I hope that the measures which have already been instigated by the Trust, in conjunction with the additional recommendations which I made, will help improve communication with patients with colorectal cancer and with their families, by enhancing the support and information available to them. **(200900766)**

### Care and Treatment

This complaint related to the actions of the Belfast Health and Social Care Trust (the Trust) in relation to the care and treatment it provided to the complainant's late wife. The complainant was concerned that his wife could be discharged from Belfast City Hospital after being told she was clear of a fungal lung infection, only to be diagnosed with the same infection 24 hours later in Antrim Area Hospital. The complainant also felt that the standard of communication between himself and the medical Professor involved in his wife's care was poor and did not allow him to be present to support his wife at what was for a family a difficult time. The complainant was unhappy about some comments made by the medical Professor, as well as her overall approach to dealing with patients and their families at a very difficult time.

Following consideration of the issues raised and having taken Independent Professional Advice, I was satisfied that the complainant's wife was discharged appropriately from Belfast City Hospital and that the Trust could not have foreseen that she would require hospital admission the following day as a result of a clinically different infection.

However, it was clear that communication between Trust staff and the complainant could, and should, have been of a significantly higher standard. I recommended that the Chief Executive of the Trust should formally apologise to the complainant for both the poor level of communication he experienced and for the comments made by the medical Professor.

In addition, evidence of poor documentation in the medical notes led me to emphasise to the Trust the need to address the poor level of record-keeping and to recommend that the Trust reviewed the standard of record-keeping in light of the deficiencies identified in my report. **(201100401)**

### Alleged Administrative Failures

The complainant in this case lived with her elderly disabled mother for whom she was the principal carer. She had several issues of complaint concerning the involvement of the Belfast Health and Social Care Trust (the Trust) in her mother's case, including:

- failure to give the complainant notice of a home visit;
- failure to invite the complainant to a relevant meeting;
- failure to disclose relevant notes of Trust activities / meetings;
- continued involvement of a particular nurse against whom a complaint had been made;
- communication with a relative against her mother's legally stated wishes; and
- an inadequate level of detail in minutes of a particular Trust meeting following a visit to the complainant's home.

I found that the Trust had failed to give notice of a home visit and failed to invite the complainant to a relevant meeting. I was satisfied that these failings constituted maladministration and were a source of inconvenience, anxiety and frustration for the complainant. I recommended that the Trust should make a total payment of £500 to the complainant and apologise in writing. The Chief Executive of the Trust accepted my recommendation.

With regard to the disclosure of information, I was not satisfied that the complainant had responded to the Trust with the required authorisation from her mother, or evidence of the legal basis upon which she could act on behalf of her mother. I referred the complainant to the Information Commissioner if she believed that such requirements were not necessary.

The Trust informed me that the particular lead nurse had moved to another post and that, should she return to the relevant unit, responsibility for the complainant's mother would be undertaken by a colleague from another team. I accepted this proposal as representing an acceptable resolution of the complaint.

I referred the complainant to the Information Commissioner regarding her complaint that the Trust had communicated with a relative against her mother's legally stated wishes.

I advised the complainant to write to the Trust and provide the necessary detail she felt was missing from the relevant minutes, thereby providing the clarification she felt was required for the Trust's administrative record. **(201100868)**

## Regional Health and Social Care Board / Health Service Providers – Dental Care Practice

### Care and Treatment

This complaint relates to the care and treatment provided to the complainant by his Dental Care Practice (the Practice) which he claimed resulted in the unnecessary loss of two teeth. The complainant stated that, following the extraction of a tooth, he experienced prolonged problems, which were not recognised or accepted by the Practice. He stated that appropriate aftercare was not offered to him by the Practice. He claimed that the Practice refused to give him appointments at a time when he was in terrible pain and his jaw was badly swollen. He believed that the repeated antibiotics prescribed to him by the Practice had contributed to current health problems he was experiencing.

The complainant indicated that he had complained verbally to the Practice, and following unsuccessful attempts to reach an agreed understanding and solution to his problem, he progressed the matter through the Regional Health and Social Care Board (the Board). Following further attempts to resolve

his complaint, he remained unhappy with the outcome of local resolution, and submitted his complaint to my Office.

Having carefully examined all of the information and documentation I obtained in the course of this investigation, including independent professional advice, I am of the view that the care and treatment provided to the complainant was of a reasonable standard. I have also examined the handling of the complaint by the Practice, and have found that the approach they adopted in dealing with the complainant's concerns at the time was appropriate, in terms of attempting to resolve his problems. I therefore did not uphold the complaint.

However, in relation to the Board's handling of the complaint, I noted that they acted in the role of 'Honest Broker' to facilitate a resolution. Following attempts by the Board to resolve the complaint, the complainant remained unhappy with the outcome and felt his distress has been compounded by the handling of his complaint by the Board over a 16 month period.

I examined all of the evidence and made a finding of maladministration, as the Board had failed to properly fulfill its role as 'Honest Broker' in facilitating a resolution to the complaint. I was of the view that the complainant was not given clear instructions as to what to expect in terms of the involvement of the Board in the role of 'Honest Broker', nor was information that would have been important in facilitating a resolution shared with him by the Board. I found that the Board failed to recognise that it was pursuing a line from which no satisfactory outcome could be achieved. Furthermore, when it was clear that conciliation / local resolution had failed, the Board failed to acknowledge this, and continued in its attempts to resolve the complaint by insisting on options, despite the complainant having indicated and stated that he did not want to pursue the options they were proposing.

In terms of a remedy, I recommend that the complainant should receive an apology from the Board for its failure to:

- fully explain to the complainant the Board's role in dealing with his complaint;
- communicate clearly with the complainant and the Practice;
- share communications with the complainant and the Practice which resulted in delayed resolution of the complaint;
- provide the complainant with the relevant and appropriate information that would have enabled him to view the documentation he had requested;
- to recognise at critical points in the process that local resolution was exhausted which resulted in an unacceptable delay in the complaint being brought to this Office; and
- to maintain records of communication with the complainant.

As a consequence of these failures by the Board, I also recommended that the complainant receive an apology for the time, trouble and frustration these failures have caused him in pursuing his complaint. I also recommended that the Board's guidance leaflet on "How To Make A Complaint" should be amended to include descriptions of the Board's role as 'Honest Broker'. I am pleased to note that the Board has accepted my recommendations. **(201100854 & 201100882)**

## Health Service Providers – GP

### Removal from GP List

This complaint related to the circumstances of both the complainant and his late wife's removal from their General Practitioner's patient list, and the Practice's handling of his subsequent complaint. As the complainant remained dissatisfied having invoked both stages of the Health & Personal Social Services (HPSS) Complaints Procedure, he referred his complaint to me.

In conducting this investigation, I considered the response the complainant received from the Convenor of the Eastern Health & Social Services Board (the EHSSB), and the complaints documentation provided to me. I also considered the medical records relating to both the complainant and his late wife, and received advice from my Independent Professional Advisor (IPA).

As a result of my consideration of this complaint I identified several incidences of maladministration by the Practice in respect of its complaints handling, the removal of the couple from its patient list, and its standard of record keeping. Accordingly, I upheld the complaint and recommended that the Practice issue the complainant with a comprehensive apology and a payment of £500, in recognition of the identified failings and the inconvenience caused to the complainant in having to bring his complaint to me.

I am pleased to report that the Practice confirmed to me its intention to comply with all of my recommendations. **(201000057)**

### Care and Treatment

I received a complaint from a lady about the care and treatment provided to her son by his GP Practice (the Practice). Her son had attended the Practice with a 3-4 week history of loose stools, brown coloured leakage from the back passage and intermittent abdominal cramps in his lower abdomen which was severe at times. An urgent referral was made for an outpatient appointment with a General Surgeon. Tragically, the complainant's son died suddenly shortly afterwards of cardiac sarcoidosis.

In an attempt to gain an understanding of what had happened to her son, the complainant met with a GP from the Practice shortly after her son's death. Specifically, she sought to understand how such a fatal condition could have gone undiagnosed by the Practice. Despite the meeting and a written response, she remained dissatisfied with the answers she received from the Practice, and asked me to investigate her concerns.

I understand how difficult it must be for the complainant and her family to come to terms with the sad loss of her only son. In investigating this case, I endeavoured to address the complainant's concerns surrounding the care and treatment provided to her son by the Practice.

Having investigated this case thoroughly and informed by Independent Professional Advice, I was satisfied that the clinical care provided by the Practice was of a reasonable standard and that GPs at the Practice could not have been expected to readily diagnose this rare condition given the symptoms which were presented at that time.

My investigation also concluded that the Practice's handling of the complaint was satisfactory and that the complainant's concerns were appropriately addressed. I did not, therefore, upheld this complaint. **(13433)**

## Northern Health and Social Care Trust

### Care and Treatment

This complaint relates to the treatment afforded to the complainant's child by Antrim Area Hospital following its decision to invoke child protection procedures, and how they were treated by staff during the process.

In conducting this investigation, I considered the medical records and complaints documentation made available to me by the Northern Health and Social Care Trust (the Trust). I also received Independent Professional advice from a Consultant Radiologist and a Consultant Paediatrician, both with extensive experience in Paediatrics.

My investigation found that the Trust misinterpreted the child's initial chest x-ray, which I consider could have resulted in less invasive further testing on the child, had the radiologist, who provided the second opinion, appropriately referred to professionally recognised radiological material. I, therefore, considered this to constitute maladministration and upheld this aspect of the complaint. However, whilst I accepted that the Trust misinterpreted the child's initial x-ray, I considered that the Trust acted in 'good faith' in initiating child protection procedures thereafter, and appropriately followed relevant published guidelines and its child protection policy. Therefore, I did not uphold this aspect of the complaint.

In addition, I identified failings in the communication with the family by the hospital professionals and, although I criticised the Trust for these, I did not consider these failings to be significant enough to warrant a finding of maladministration. **(201000769)**

### Care and Treatment

I received a complaint regarding the quality of care and treatment provided to the complainant's father whilst a patient in Antrim Area Hospital. She also complained about the Northern Health and Social Care Trust's (the Trust) handling of her complaint.

The complainant's father was admitted to Antrim Area Hospital suffering from septicaemia. Whilst in hospital, he slipped and fell in the ward. He reported pain in his left ankle and right shin and after examination, an x-ray was requested on his right leg which was carried out the following days. This reported no damage to his right leg and he was then given physiotherapy. He continued to complain about pain in his left ankle and three days after the initial x-ray, a further x-ray showed that his left ankle was fractured.

The complainant stated to the Trust that as a result of inadequate care, her father suffered unnecessary pain caused by a rehabilitation programme which was initiated before a diagnosis of the full extent of damage resulting from the fall was identified.

Having obtained independent professional advice, I was satisfied that the clinical care provided was of a reasonable standard. I found some minor shortcomings in the Trust's assessment / care planning process but I am satisfied that this did not impact on the complainant's father's long term medical needs. However, I did find that the Trust's handling of the complaint fell below the expected standard and that the Trust failed to follow its procedures when an incident of this nature happens In terms of remedy, I recommended that the Trust issue an apology to the complainant for its failures in following incident management policy and procedure following her father's fall and for the inadequate, inaccurate responses issued to the complainant at local resolution stage, and for the failure to acknowledge mistakes and offer an appropriate apology

I recommended that a payment of £250 be made to the complainant in recognition of the clear distress and frustration experienced by her in pursuing her concerns through the complaints procedure.
**(201001220)**

## Care and Treatment

This complaint relates to the care and treatment provided to the complainant's wife by the Antrim Area Hospital. The complainant's wife had a long-standing back complaint, which was causing her significant pain and, as a result, she was receiving treatment from her General Practitioner. She subsequently presented at the Emergency Department of Antrim Area Hospital with back, chest and abdominal pain. Following investigation, she was diagnosed with advanced lung cancer, and in the months thereafter she received regular in and outpatient care at various facilities. Sadly, the lady's condition deteriorated and she passed away.

Her husband, complained to their family GP about the standard of treatment his wife had received. He copied his letter to the NI Minister for Health, as well as the Chief Executives of both the Belfast and Northern Health and Social Care Trusts. As he remained dissatisfied following local resolution of these complaints, the complainant contacted my Office and requested that I investigate his case.

During the course of my investigation, I investigated a number of issues of complaint, including:

- the lady's discharge from Antrim Area Hospital;
- the delay in a biopsy being undertaken;
- the circumstances surrounding the lady's fractured humerus bone;
- the interpretation of the lady's x-rays; and
- the decision to provide the lady with a chicken curry meal two days after she had undergone surgery on her bowel.

Following receipt of the complaint, I corresponded with the Northern Health and Social Care Trust (the Trust) in respect of the issues raised, and requested all of the background documentation pertaining to his wife's treatment, including her medical records. To assist with my consideration of the clinical issues raised, I requested advice from three Independent Professional Advisors (IPAs), specialising in surgery, general medicine and nursing.

My investigation determined that the lady's discharge was inappropriate and that she required further inpatient care at that time. Although I considered this failing to constitute maladministration, in accordance with the advice of my General Medicine IPA, it was my view that the failure to admit the complainant's wife on this date did not affect her prognosis or the eventual outcome of her illness. Therefore, I upheld this aspect of the complaint and recommended that the Trust issue an apology to the complainant.

Having considered all of the evidence available to me and the advice of my Nursing IPA, it was my view that it cannot be reliably determined that the actions of Trust staff caused the lady's fracture. This was due to the nature of the evidence available to me, and taking account of the lady's own physical condition at the time. I am satisfied, however, that the use of a hoist was given adequate consideration and was ruled out following the conclusion of a risk assessment. My Nursing IPA identified some examples of poor record keeping, and I have reminded the Trust of the requirements of relevant guidance in this area.

Whilst I was in agreement with the complainant that his wife's biopsy was unduly delayed, and that she was provided with an inappropriate meal following her surgery, I noted that the Trust had admitted to these failings in her care during the local resolution stage of the examination of his complaint. As part of that admission, the Trust had offered apologies to the complainant for these failures. Accordingly, I

determined that no further action by my Office was necessary. My investigation also determined that the time taken to interpret the x-rays was reasonable and in line with the advice received from my Surgical IPA. **(201100563)**

## Northern Ireland Ambulance Service Trust

### Care and Treatment

This complaint related to the care and treatment provided by the Northern Ireland Ambulance Service (NIAS) to the complainant's husband. In particular, the complainant was dissatisfied with:

- the ambulance response time;
- the care and treatment provided by the ambulance crew; and
- the conduct of the ambulance crew.

I carefully examined the information provided to me by NIAS in relation to this complaint and sought advice from my Independent Professional Advisor. I found that the care and treatment provided to the complainant's husband was of a reasonable standard and adhered to the relevant guidelines. I did not uphold this complaint. **(13157)**

## Southern Health & Social Care Trust

### Withdrawal of Meals on Wheels Service

In this case, the complainant had received a subsidised meals on wheels service from the Southern Health and Social Care Trust (the Trust) for over two years when it was withdrawn by the Trust. He complained to me that:

- the Trust had informed him by telephone that his subsidised meals on wheels service would be stopping before any reassessment of his needs had been made;
- his need for a ready prepared meal had been identified by the Trust but this need was not being met; and
- none of the criteria for terminating access to a subsidised meals on wheels service had been met.

The Trust denied informing the complainant by telephone that the subsidised service would be stopping before any reassessment of his needs had been made. I was unable to find any evidence to establish what had been said during any phone calls that occurred between the Trust and the complainant prior to the withdrawal of the service.

My investigation found that the criteria for assessing entitlement to a subsidised service had changed. In particular, if ready prepared meals were available from an alternative source, the revised criteria gave no entitlement to a subsidised service. According to the Trust, an assessment of the complainant's needs under the new criteria indicated that he still had an identified need for a ready prepared meal. However, since the complainant had the opportunity to purchase ready prepared meals from a variety of suppliers, he was deemed no longer to be eligible to receive a subsidised service. I also found that these circumstances fulfilled the criteria for terminating access to a subsidised service. Against this background, I was unable to question the Trust's withdrawal of its subsidised meals on wheels service from the complainant. I did not uphold this complaint. **(201100824)**

### Care and Treatment

This complainant contacted me about the care and treatment provided to her late husband by the Southern Health and Social Care Trust (the Trust). In particular she felt that, at her husband's admission, the doctor in the emergency department should have had results of investigations that had been carried out the previous week. She was also not satisfied with the nursing care provided to her husband in terms of personal hygiene care; collection of stool sample; record of weight; wound care; and quality of nursing notes. The complainant also questioned the Trust's diagnosis of her husband's condition, the decision to discharge him and information regarding his acquisition of Clostridium difficile infection.

I investigated the complaint and found no maladministration in respect of the actions of the doctor in the emergency department, the Trust's diagnosis of her husband's condition, the decision to discharge him or in relation to information regarding his becoming infected with Clostridium difficile. There was evidence that the Trust's nursing care was not of a reasonable standard in relation to personal hygiene care and the collection of stool samples but I noted that the Trust had acknowledged these failings at local resolution stage.

I found maladministration in relation to how the Trust recorded the complainant's husband's weight, his wound care and the quality of nursing notes. The Trust advised me that it had introduced a series of initiatives to address the identified failings. I reminded the Trust that procedures had previously been in place to avoid these failing but were not followed; therefore it is imperative to ensure that staff follow procedures. I recommended that the Trust provide the complainant with an apology and a payment of £1,000 in recognition of the injustice suffered by her late husband because of the Trust's failings and in recognition of her effort in pursuing her complaint. I am pleased to record that the Trust accepted my recommendations. **(13191)**

## South Eastern Health and Social Care Trust

### Care and Treatment

This complaint related to the care and treatment afforded to the complainant by the South Eastern Health and Social Care Trust (the Trust) during her labour and the birth of her son, at the Maternity Unit in the Ulster Hospital.

Whilst her complaint was presented in the form of some 23 issues, the overriding focus of her complaint was that she had not been given a satisfactory explanation of why her baby son experienced an ischemic insult at birth, and whether any element of the care she received during her antenatal or labour period had contributed to the difficulties her baby experienced as a new born.

To assist with the investigation of the complaint I obtained advice from my three Independent Professional Advisors, two of whom worked in the field of Obstetrics and the other was a Consultant Neonatal Paediatrician. I also considered a large volume of documentation and medical records made available to him by the Trust.

As a result of my consideration of the complaint I concluded that the care and treatment afforded to the complainant during her labour and the delivery of her baby son was attended by maladministration. Furthermore I found that the Trust made no attempt to explain the likely causes of the difficulties that the baby experienced and had in fact adopted an evasive approach, which clearly served only to undermine the complainant's trust and confidence in the care provided.

Given the inadequacies and failings I identified, in respect of both the care and treatment provided and the inadequacy of the Trust's complaints handling process, I made a series of recommendations, including the issuing of a comprehensive apology and a payment of £5000 in recognition of the distress caused. All of the recommendations were accepted by the Trust. **(200900787)**

### Complaint Handling / Administration

I received a complaint concerning the actions of the South Eastern Health & Social Care Trust (the Trust). The complaint centred on the Case Management Review (CMR), which was convened following the tragic death of the complainant's daughter in 2006, and also on the actions of social work staff.

My initial focus on this complaint was how it was managed through the Trust's complaints procedure. Following my consideration of the documentation available, I concluded that the Trust made a committed and comprehensive effort to address and resolve the complainant's concerns. I considered that the detail of the responses provided by the Chief Executive, and the meetings facilitated by the Trust to enable the complainant to meet with a senior member of Trust staff and other staff members, supported the view that the Trust took this complaint seriously and gave it appropriate, proportionate and detailed consideration. Overall, I concluded that the Trust handled this complaint properly under its complaints procedure.

In my consideration of this complaint I was conscious that the CMR did not examine the role of the Trust in isolation. The review panel looked at the roles played by health services, education, police and juvenile justice and made recommendations to each of the organisations involved. I was of the view that the CMR complied with its terms of reference, and that it provided a comprehensive assessment of the interaction between the complainant's daughter, her family, and social services during the relevant period. I also noted that the recommendations of the CMR led the Trust, and all other agencies involved in the review process, to agree and implement an action plan with specific reference to the complainant's daughter's case, with the objective of improving procedures, services and inter-agency co-operation. I considered that the recommendations made as a result of the CMR, resulted in an action plan and other initiatives that had the potential to improve the quality of care offered by Trust staff in this complex and challenging area of their professional practice. I

did not consider that a further investigation by my office into the actions of social work staff in this case would produce a different outcome or further insight into the circumstances surrounding the complainant's daughter's tragic death.

Having carried out a detailed examination of the case I did not identify any evidence of maladministration on the part of the Trust. **(201000714)**

## Handling of Mother's Care Home Arrangements

In this case, the complainant was in dispute with the South Eastern Health and Social Care Trust (the Trust) about the payment of nursing home fees, and he was unhappy about the handling of his elderly mother's admission to a private nursing home. He complained that the Trust:

- failed to advise of the potential impact on benefit entitlement;
- failed to initiate the payment of nursing home fees via itself;
- failed to keep proper records;
- was responsible for confusion regarding the applicability of top-up fees;
- failed to provide a comprehensive needs assessment and care plan;
- was responsible for delay in the provision of requested information;
- failed to comply with relevant guidelines;
- failed to respond to correspondence.

After a detailed investigation, I partially upheld the complaint in respect of a failure to provide advice relating to possible impact on benefits, and, delay in the provision of information. My findings in this case turned on the fact that the complainant's mother was self-funding due to the level of her assets, which I found limited the Trust's responsibilities. I also noted that three years after admission to the nursing home, the complainant had stopped paying the nursing home fees and failed to provide the Trust with details of his mother's financial standing in order for the Trust to determine whether it had a responsibility for meeting the cost of his mother's nursing care.

In respect of the maladministration identified, I recommended that the Trust make a payment of £300 to the complainant together with a written apology for the specific failings. The Chief Executive of the Trust accepted my recommendations. **(201000981)**

## Care and Treatment

This complaint related to care and treatment provided to the complainant's husband while he was a patient at the Ulster Hospital. The complainant was unhappy that her husband was given an injection containing adrenaline despite being allergic to it, had his wishes ignored by the doctor treating him, and had his health put at risk as a result. She was also dissatisfied with the approach to hygiene adopted by the doctor treating her husband. In addition, she complained that the doctor involved carried out the procedure on her husband without obtaining his consent, and only obtained consent after her husband had recovered from fainting during the procedure.

Following consideration of the issues raised, and having taken independent professional advice, I considered that this was principally an issue of a failed consent procedure, and that the doctor treating the complainant's husband continued with a procedure despite it being counter to the wishes of the patient. I was unable to conclude that the use of adrenalin caused the reaction experienced by the complainant's husband although I was satisfied that the overall clinical outcome of the treatment was not adversely affected by the procedure. I am satisfied that the South Eastern Health and Social Care Trust (the Trust) has learned from this incident and I recommended that the Trust undertake a review of the awareness and compliance with informed consent procedures across all clinical settings. I was also satisfied that the Trust's response to addressing the hygiene issue was reasonable and that steps have been taken to learn from this aspect of the complaint.

I also recommended that the Trust provide the complainant and her husband with an apology for failing to conduct the consent procedure properly and for failing to take account of the patient's wishes before carrying out the procedure. I also recommended that the Trust makes a payment of £1,000 to the complainant's husband in recognition of the distress, anxiety and frustration he experienced through not being listened to and not having his wishes taken into account. **(201100922)**

Appendix
A

# APPENDIX B

## KEY PERFORMANCE INDICATORS

# Key Performance Indicators

Appendix B

Accountability for our performance against the plans and targets that we set is a fundamental principle of the Office. These performance targets focus on the time taken to complete our investigations. Qualitative assessments are completed through established internal procedures. The Office's performance against these targets is detailed below.

## KPI 1

Measures how quickly we carry out the validation to determine whether the complaint can or should be accepted for investigation by this Office. We aim to tell the complainant within 21 calendar days or less of that decision. The target is 90%.

KPI 1 was met in **89%** of cases (88% 2011-12).

## KPI 2

Measures how quickly we identify an opportunity for early resolution to a case. Our aim is to inform complainants of this decision within 3 months or less. The target is 90% of those cases identified.

KPI 2 was met in **75%** of cases (82% 2011-12), 3 out of 4 cases. The fourth case exceeded the target by 8 days.

## KPI 3

Measures how quickly we make a decision on cases we accept for preliminary investigation. Our target is to complete case closure in 90% of cases within 6 months or less.

KPI 3 was met in **89%** of cases (80% 2011-12).

## KPI 4

Measures the time taken to complete the draft report in cases which we accept for investigation. Our target is to complete 80% of cases within 12 months or less.

KPI 4 was met in **75%** of cases (61% 2011-12). However, further analysis of complaints, which moved to detailed investigation, indicates that 83% of cases were completed to draft report stage within a 13 month timeframe.

The time we spend on investigating cases is important to individuals making complaints. Our priority during a period of major change and challenge for the Office is to seek improvement in terms of outcomes against our KPIs. This is reflected in our performance at 31 March 2013, when we showed improvement in three of the four KPIs measured last year. These improvements have been assisted by optimising the potential of our new technology platform to improve organisational efficiency and effectiveness.

# APPENDIX C

## KEY ACTIVITIES 2012/13 AND FINANCIAL SUMMARY

# Other Key Areas Addressed in 2012/13

Appendix C

This year was the third year of the 2010/13 Strategic Plan which was developed in 2010 following a comprehensive review of the Office in 2009/10. This review included examination of the core values of the Office, Outreach Strategy, investigation processes and the office structure. The strategic aims and objectives outlined in the Plan relate to three discrete areas:

- Benefits for Individuals;
- Improving Public Services; and
- Modernising the Ombudsman's Office

The Office reviews and refines its Strategic Plan annually. It was agreed that the objectives set remained valid for 2012/13, given the ongoing strategic context as set out in the Strategic Plan. Having reviewed the objectives to ascertain whether they require any adjustment to reflect the changing external environment such as the realignment of public services, reducing budgets across the public service and the need to ensure the Office remains 'fit for purpose' should the new legislation be enacted, the Office has decided to roll forward the current Strategic Plan for a further period of 12 months. The decision to extend the current Strategic Plan, rather than to establish a new three year Strategic Plan, is primarily due to the challenges of the new legislation which is under development at this time. It would be impractical to develop a Strategic Plan for the next three to five years until the detail of the Office's legislative reform has been agreed and a draft Bill approved by the Assembly. It is envisaged that the timescale for the enactment of the new legislation and Royal Assent will be 2014.

## Benefits for Individuals

The core business of my Office currently remains the investigation of complaints of maladministration and it is necessary to ensure that all investigations are completed within the timescale specified and with no loss of quality. The validation and investigations policies have now been imbedded to ensure that the investigation resource is allocated fairly and proportionately. By applying the tests of proportionality, public interest and practical outcome, it is anticipated that this will ensure a continued focus on the successful early assessment of cases.

## Improving Public Services

As part of my aim to improve public services I will continue through my recommendations to seek to contribute to improvements in public services and this objective will remain in the Strategic Plan. Of the recommendations which I have made over the period covered by the Strategic Plan, 41% were for service improvements or change. My Office has also been involved in a joint project with the Public Record Office Northern Ireland in relation to the appreciation of the Principles of Good Administration in the important area of record keeping and joint guidance from both Offices will be published in the autumn of 2013.

## Modernising the Ombudsman's Office

A new computerised Case Management System was developed in 2010/11 and went live in April 2012. I am pleased to note that post project evaluation has demonstrated that all milestones, timescales and objectives were met. The increased number of performance reports that can be produced through the project have proved useful in ensuring improved and timely performance management data is available for the Senior Management Team and Audit Committee.

In the summer of 2012 a restructuring project was launched to move the office to generalist teams and to restructure the administration and front of office to ensure a more responsive service to the public. The project was launched in May 2013 with the setting up of the Advice Support Service and Initial Screening Team (ASSIST) and two Investigation Teams.

Both myself and my Deputy have been liaising with DOE officials regarding my Office taking responsibility for the investigation of complaints made under the proposed Local Government Code of Conduct for Councillors. Legislation to amend the Commissioner for Complaints (NI) Order 1996 will be introduced in the Assembly with legislative change anticipated to be in place by May 2014.

# Financial Summary

The Assembly Ombudsman for Northern Ireland and the Northern Ireland Commissioner for Complaint's (AOCC) full Resource Accounts 2012/13 will be laid before the Northern Ireland Assembly in July 2013 and will be available on our website at www.ni-ombudsman.org.uk.

## Summary Financial Statements for the year ended 31 March 2013

The following Financial Statements are a summary of the information extracted from the AOCC's full annual Resource Accounts for 2012/13. The full annual Resource Accounts and auditors report should be consulted for further information.

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

## Financial Review

The Office set four financial management targets. The performance against each was as follows:

- KPI 5: We will not exceed the total Net Total Resource expenditure for the year authorised by the Northern Ireland Assembly as detailed in the 2012/13 Spring Supplementary Estimate, limiting any underspend to less than 2%;

  The Net Total Resource allocated to the Office for 2012/13 was £1.569 million. The actual net resource outturn equalled £1.51 million. Therefore, the actual amount of resource required was £59k less than the Estimate. This represented an underspend of 3.8% (3.9% in 2011/12)

- KPI 6: We will not exceed the capital expenditure for the year authorised by the Northern Ireland Assembly as detailed in the 2012/13 Spring Supplementary Estimate, limiting any underspend to less than 2%;

  Actual capital expenditure amounted to £1k, which was equal to the estimated figure.

- KPI 7: In supporting the work of the Office, the total of cash utilised within the year will not exceed the Net Cash Requirement limit authorised by the Northern Ireland Assembly as detailed in the 2012/13 Spring Supplementary Estimate;

  The Net Cash allocation for the Office for 2012/13 was £1.515 million. The actual Net Cash requirement was £1.456 million, an underspend of £59k (3.9%).

- KPI 8: We will pay 99% of correctly presented supplier invoices within 10 days of receipt.

  Payment was made within 10 days of receipt of a correctly presented supplier invoice in 99.1% of payments (99.8% in 2011/12).

The result against KPI 5 and KPI 7 has been directly affected by:

The rescheduling of judicial review challenges on the part of the applicant, which resulted in a reduction against legal expenditure forecast. This reduction equalled £24k, 40% of the total underspend.

The unplanned departure of staff on promotion or leaving the service, during the last quarter of the financial year, and delays in the replacement of administrative staff were outside the control of the Office. This resulted in a reduction against the salary expenditure forecast. This reduction equalled £13k, 12% of the total underspend. These departures also affected the holiday pay accrual and associated general expenditure e.g. telephone, electricity and office consumables.

Staff costs for the year amounted to £1.104 million compared with £1.277 million in the previous financial year. This equalled 73% of the actual total resource expenditure compared with 75.5% recorded in 2011/12. The remainder of the expenditure is split between property rent and rates, premises expenses, travel and subsistence, consultancy and other general office expenditure.

Appendix C

## Summary of Resource Outturn 2012/13

| | 2012/13 £000 Estimate | Outturn | | | | | | 2011/12 £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 | 1,569 | - | 1,569 | 1,510 | - | 1,510 | 59 | 1,691 |
| **Total resources** | **1,569** | **-** | **1,569** | **1,510** | **-** | **1,510** | **59** | **1,691** |
| Non-operating cost AR | - | - | - | - | - | - | - | - |

## Net cash requirement 2012/13

| | Estimate | Outturn | 2012/13 £000 Net total outturn compared with estimate: saving/ (excess) | 2011/12 £000 Outturn |
|---|---|---|---|---|
| Net cash requirement | 1,515 | 1,456 | 59 | 1,703 |

## Statement of Comprehensive Net Expenditure

for the year ended 31 March 2013

| | 2012/13 £000 | | | | 2011/12 £000 |
|---|---|---|---|---|---|
| | Staff Costs | Other Costs | Income | Total | |
| Administration Costs (Request for resources A) | | | | | |
| Staff costs | 1,104 | - | - | 1,104 | 1,277 |
| Other administration costs | - | 582 | - | 582 | 590 |
| Operating income | - | - | (1) | (1) | (1) |
| **Totals** | **1,104** | **582** | **(1)** | **1,685** | **1,866** |
| **Net Operating Cost** | | | | **1,685** | **1,866** |

Appendix C

## Statement of Financial Position

as at 31 March 2013

| | 2013 £000 | 2012 £000 | 2011 £000 |
|---|---|---|---|
| **Non-current assets** | | | |
| Property, plant and equipment | 23 | 34 | 58 |
| Intangible assets | 76 | 97 | 32 |
| Receivables falling due after more than one year | - | - | - |
| **Total non-current assets** | 99 | 131 | 90 |
| | | | |
| **Current assets** | | | |
| Inventories | - | - | - |
| Trade and other receivables | 60 | 63 | 75 |
| Cash and cash equivalents | 27 | 33 | 5 |
| **Total current assets** | 87 | 96 | 80 |
| **Total assets** | **186** | **227** | **170** |
| | | | |
| **Current liabilities** | | | |
| Trade and other payables | (59) | (68) | (34) |
| **Total current liabilities** | (59) | (68) | (34) |
| **Non-current assets plus/less net current assets/liabilities** | **127** | **159** | **136** |
| | | | |
| **Non-current liabilities** | | | |
| Provisions | - | - | - |
| **Total non-current liabilities** | - | - | - |
| **Total assets less liabilities** | **127** | **159** | **136** |
| | | | |
| **Taxpayers' equity & other reserves:** | | | |
| General fund | 117 | 142 | 119 |
| Revaluation reserve | 10 | 17 | 17 |
| Charitable funds | - | - | - |
| **Total equity** | **127** | **159** | **136** |

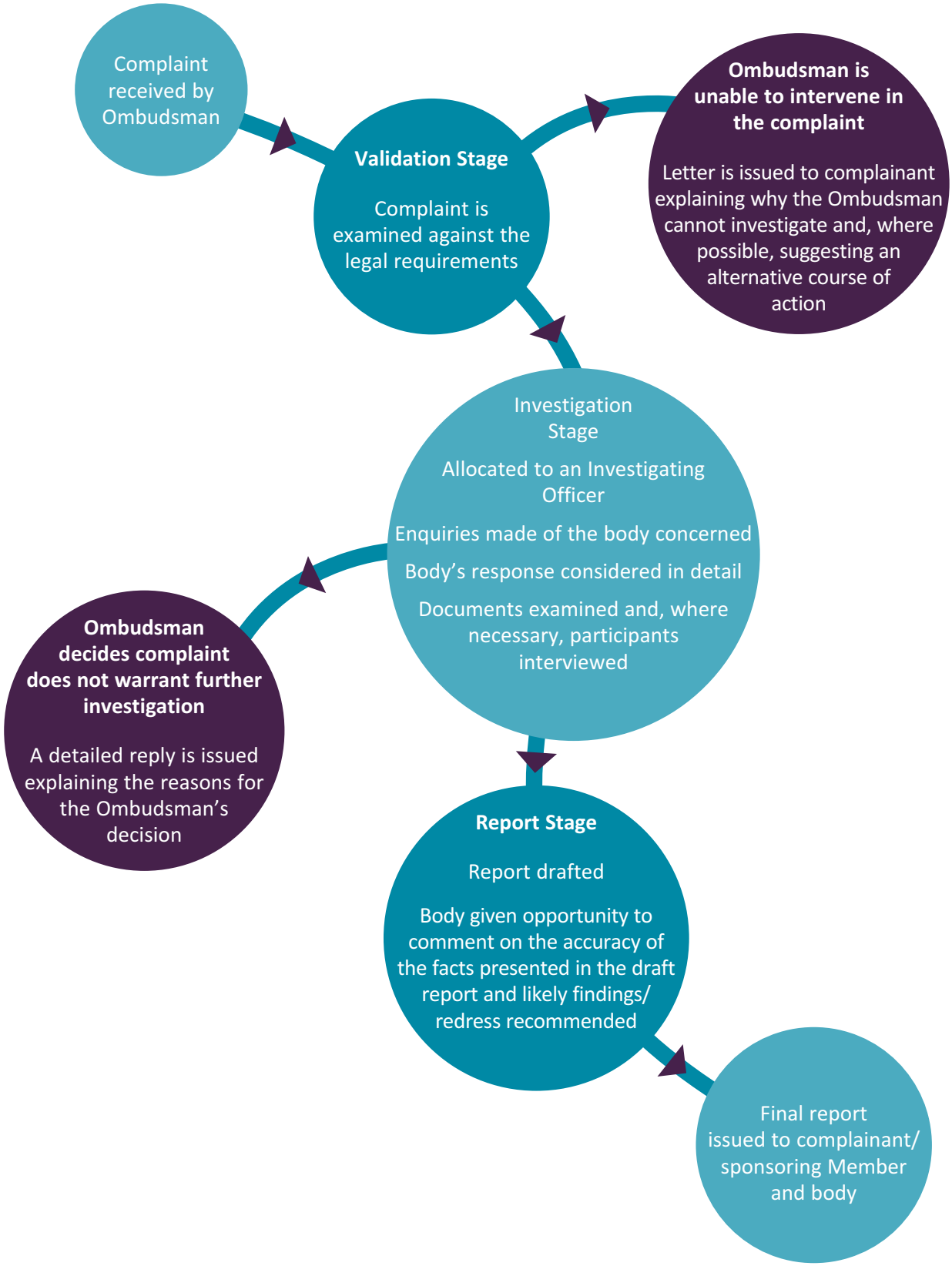
# APPENDIX D

## HANDLING OF COMPLAINTS

# Investigation of Complaints

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

Appendix D



# The Process for Assessing and Investigating Complaints

## Validation Stage

Each written complaint is checked to ensure that:

- the body complained of is within jurisdiction;
- the matter complained of is within jurisdiction;
- the complainant may bring a complaint;
- 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, the complainant / MLA will be advised why I cannot investigate the complaint. Where possible, this correspondence will detail a course of action which has a greater statutory competence to deal with 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 eligible for investigation, it is referred to the Investigation Stage (see below). The Office target for a decision on whether we will investigate 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 and social care complaints 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 led to an injustice to the complainant – the investigation of the case will continue (see below).

If, at this stage of the investigation, I conclude that there is maladministration and injustice, 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 recommendations, 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 of a complaint 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 or social care 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

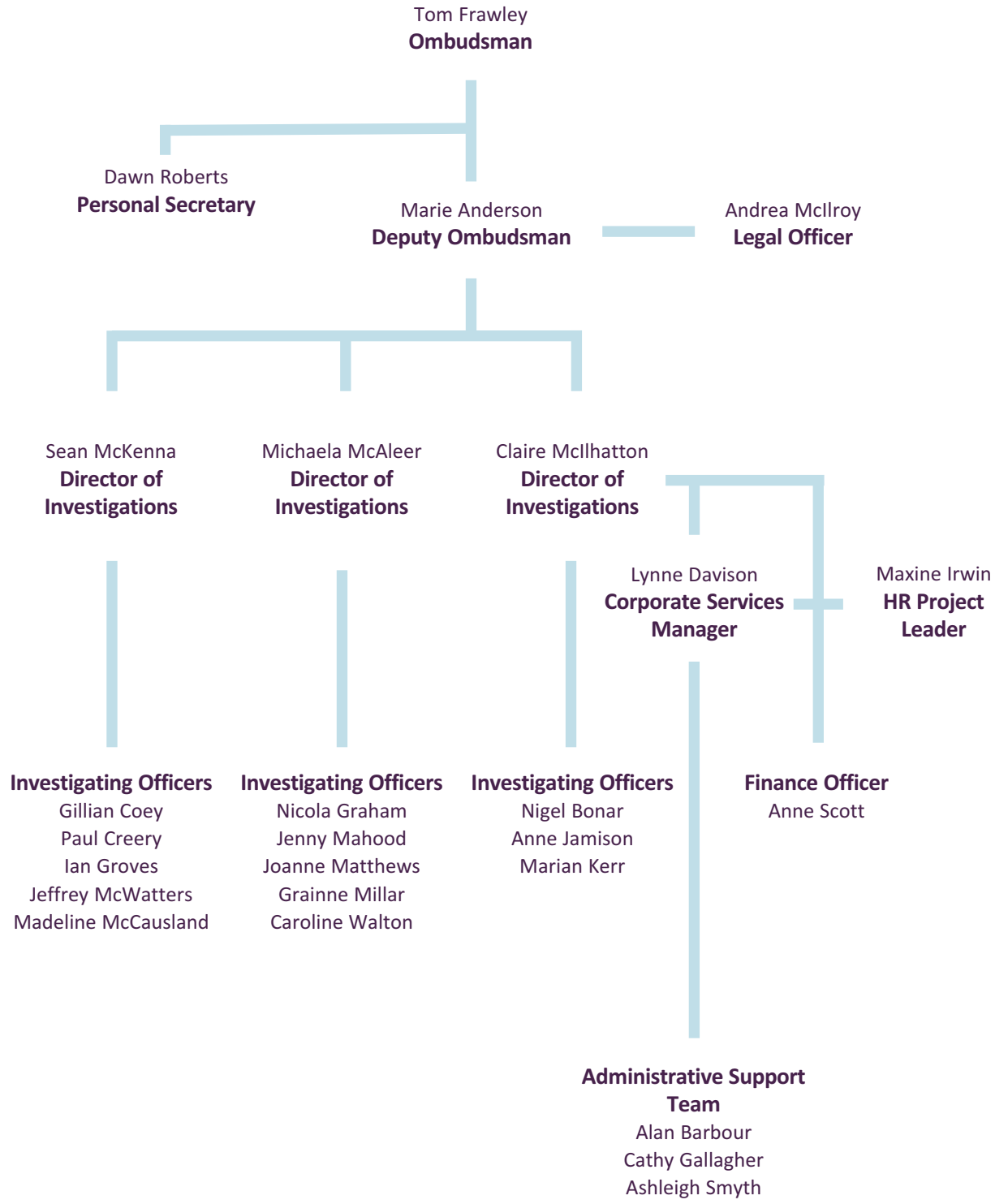
I will prepare a draft report containing the facts of the case and my likely findings. The body concerned will be given an opportunity to comment on the accuracy of the facts as presented, my likely findings and any redress I propose to recommend. Following receipt of any comments which the body may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

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 E

## STAFF ORGANISATION CHART

Appendix E


Tom Frawley
Ombudsman
Dawn Roberts
Personal Secretary
Marie Anderson
Deputy Ombudsman
Andrea McIlroy
Legal Officer
Sean McKenna
Director of Investigations
Michaela McAleer
Director of Investigations
Claire McIlhatton
Director of Investigations
Lynne Davison
Corporate Services Manager
Maxine Irwin
HR Project Leader
Investigating Officers
Gillian Coey
Paul Creery
Ian Groves
Jeffrey McWatters
Madeline McCausland
Investigating Officers
Nicola Graham
Jenny Mahood
Joanne Matthews
Grainne Millar
Caroline Walton
Investigating Officers
Nigel Bonar
Anne Jamison
Marian Kerr
Finance Officer
Anne Scott
Administrative Support Team
Alan Barbour
Cathy Gallagher
Ashleigh Smyth

# Contacting the Office

In accordance with the legislation underpinning the work of my Office, access to my Office and the investigations service I provide aims to be accessible and user-friendly. Experienced staff are available during office hours to provide advice and assistance to help determine the complaint. 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. The sponsorship of a Member of the Legislative Assembly (MLA) is required when the complaint is about a government department or one of their statutory 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, or refer the complainant to an advocacy service. I aim to be accessible to all who contact us.

An information leaflet is made widely available through the bodies within my jurisdiction; libraries; advice centres; etc. It is available: in large print form; and as an audio cassette. 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 e-mail 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 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 service complaints and details of the information available from my Office under our Publication Scheme.

Northern Ireland Ombudsman


**Northern Ireland Ombudsman**

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The Northern Ireland Ombudsman
33 Wellington Place
Belfast
BT1 6HN

Tel: 028 9023 3821
Fax: 028 9023 4912
Email: ombudsman@ni-ombudsman.org.uk

www.ni-ombudsman.org.uk