Northern Ireland Ombudsman

Annual Report

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

2014 | 2015

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. In approaching a complaint of maladministration, I use the "Principles of Good Administration" (see Appendix A) as a framework.

In addition, since June 2014, the Office has powers to investigate complaints against councillors about alleged breaches of the Local Government Code of Conduct. Where required to do so I adjudicate in relation to the relevant sanctions to be applied, where appropriate if a finding of a breach of the Code has been made.

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 bodies, registered 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, Executive Departments and public bodies which I have the power to investigate. All complaints to me are treated in the strictest confidence, and the service I provide is free.

© Crown Copyright 2015

You may re-use this information (excluding logos) free of charge in any format or medium, under the terms of the Open Government Licence v.3. To view this licence, visit http://www.nationalarchives.gov.uk/doc/open-government-licence/version/3 or email@psi@nationalarchives.gsi.gov.uk

Where we have identified any third part copyright information, you will need to obtain permission from the copyright holders concerned.

This document is also available at www.ni-ombudsman.org.uk

Any enquiries regarding this document should be sent to us at: The Office of the Northern Ireland Ombudsman, Progressive House, 33 Wellington Place, Belfast BT1 6HN.

Email: ombudsman@ni-ombudsman.org.uk

ANNUAL REPORT

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

2014-15

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

Glossary of Terms

Glossary of Terms

AAH	Antrim Area Hospital	MRI	Magnetic Resonance Imaging (Scan)
ADR	Alternative Dispute Resolution	NAC	National Association of Councillors
AOCC	Assembly Ombudsman/ Commissioner for Complaints	NHSCT	Northern Health and Social Care Trust
ASSIST	Advice, Support Service and Initial Screening Team	NICS	Northern Ireland Civil Service
BCH	Belfast City Hospital	NIFRS	Northern Ireland Fire and Rescue Service
BHSCT	Belfast Health and Social Care Trust	NIHE	Northern Ireland Housing Executive
CAH	Craigavon Area Hospital	NIHRC	Northern Ireland Human Rights Commission
CT	Computerised Tomography (Scan)	NIJAC	Northern Ireland Judicial Appointments Commission
DARD	Deptartment of Agriculture and Rural Development	NIJAO	Northern Ireland Judicial Appointments Ombudsman
DFP	Department of Finance and Personnel	NILGA	Northern Ireland Local Government Association
DOE	Department of the Environment	NIPSO	Northern Ireland Public Services Ombudsman
DOJ	Department of Justice	OFMdFM	Office of the First Minister and Deputy First Minister
EoI	Expression of Interest	PAC	Planning Appeals Commission
FREDA	Fairness, Respect, Equality, Dignity and Autonomy	PLGG	Planning and Local Government Group (within DOE)
GP	General Practitioner	PPO	Principal Planning Officer
HSC	Health and Social Care	PRONI	Public Record Office of Northern Ireland
ICO	Information Commissioner's Office	RBHSC	Royal Belfast Hospital for Sick Children
ICPCC	Initial Child Protection Case Conference	RVH	Royal Victoria Hospital
ICU	Intensive Care Unit	SEHSCT	South Eastern Health and Social Care Trust
IOI	International Ombudsman Institute	SFP	Single Farm Payment
IPA	Independent Professional Advice	SHSCT	Southern Health and Social Care Trust
KPI	Key Performance Indicator	SOLACE	Society of Local Authority Chief Executives
LGES	Local Government Ethical Standards	SPPS	Strategic Planning Policy Statement
MDT	Multi Disciplinary Team	TPO	Tree Preservation Order
MLA	Member of the Legislative Assembly		

Section 1

The Year in Review

Section 1

The Year in Review

This is the 15th year in which I will have the honour and the privilege of presenting my annual report. The report is the document of record on the work and performance of the two statutory offices of Assembly Ombudsman for Northern Ireland and Northern Ireland Commissioner for Complaints. I have held both offices since September 2000. My overall jurisdiction is extremely wide, covering complaints from the citizen about most public services in Northern Ireland.

As Assembly Ombudsman, I have responsibility for investigating complaints of maladministration in relation to the actions of all Northern Ireland government departments and their statutory agencies. In this role I also have a shared cross border jurisdiction with the Irish Ombudsman that enables the investigation of complaints of maladministration by North-South implementation bodies. I also have a jurisdiction that allows me to investigate the administrative failures of a number of devolved tribunals that operate in Northern Ireland.

My jurisdiction as Northern Ireland Commissioner for Complaints involves the investigation of poor administration in relation to housing, local government, health and social care bodies and a diverse range of other public service providers. In the role I also have a significant jurisdiction in relation to complaints about clinical judgment involving health care professionals including doctors, consultants, GPs, dentists, pharmacists and ophthalmists. In undertaking this role, I have access to the advice of expert clinical advisors. As mine is an office of last resort I usually only investigate a complaint when the internal complaint process of the relevant body has been exhausted.

In total, my jurisdiction extends to the investigation of complaints about 172 public bodies, 11 statutory tribunals, 8 cross border bodies as well as 1,242 general practitioners, 1,211 dentists, 535 pharmacies and 642 ophthalmists. I can also investigate complaints in relation to the independent healthcare sector and, given the increasing recourse to that sector by the Health Service, this is an increasingly complex area of my work.

Trends in Complaints in 2014-15

In the year 2014-15 I received a total of 830 formal complaints. This figure represents a decrease of 15% from last year. This reduction is mainly due to the noticeable decrease in the numbers of complaints made about central government departments and their statutory agencies. There has been a 26% drop in complaints about Northern Ireland Departments - a marked decrease from 2013-14. I consider that, in part, the explanation for this is the initiative taken by the Head of the Civil Service and the Permanent Secretaries Group. This has included the dissemination of the Parliamentary and Health Service Ombudsman's *Principles of Good Complaints Handling*[1] and a streamlining of complaints processes across NICS departments and their arms length bodies as well as a requirement for information on complaints to be part of all departmental Annual Reports. This increased focus on good complaints handling at source is to be commended and encouraged as it allows bodies to take ownership of complaints and to seek to learn lessons from those complaints in order to improve public services for the benefit of the citizen. I would urge the wider public sector to adopt a similar approach.

1 See publication "Principles of Good Complaint Handling" at: http://www.ni-ombudsman.org.uk/Documents/Principles-of-Good-Complaint-Handling.aspx

A further noticeable trend is the reduction in complaints about planning matters and this again is a result of a leadership initiative in the DOE Planning and Local Government Group (PLGG) to deal with complaints at source, with the PLGG taking the learning from my earlier annual reports and investigation reports and resolving these complaints with the member of the public wherever possible. This has resulted in a 26% decrease in complaints to my office about planning matters. This decrease is attributable in the main to the commitment of the PLGG leadership and their desire to learn from complaints, whilst acknowledging and remedying errors through the complaints process.

There is also a reduction in the number of cases that are coming to my office which are outside my jurisdiction; this number has decreased from 87 in 2013-14 to 32 this year, a reduction of 63%. That can be explained as partly due to the public's increasing awareness of the bodies that are in my jurisdiction and of my powers. In September 2012 I launched a public information booklet with the Law Centre (NI) and Queens University Belfast to better inform the public of my role and that of other ombudsmen, complaints and mediation bodies. The publication, which is available on my website[2] for all complainants and their advisors, has received much external recognition. Since that time there has been a noticeable reduction each year in 'out of jurisdiction' complaints to my Office. In addition, as the work of my front-of-office Advice, Support Service and Initial Screening Team (ASSIST) is embedded, the public are better informed of my role and better able to focus their enquiries about redress for service failure towards that early resolution team. This year a total of 340 written enquiries from the public were made to my office, which is an increase of 35% on last year. ASSIST has coped well with this upsurge in enquiries.

In recent years I have been reporting ever-increasing numbers of health care cases. In 2013-14 the then-reported 31% increase in overall complaints to my office was driven by an upsurge of 46% in health cases. While complaints about health matters have decreased by 9% this year, I consider this a relatively minor decrease which represents a plateauing of the number of health cases and not necessarily a reflection of significant improvement in this area of public service. That is because, as noted in previous annual reports, since 2009 I have been reporting year-on-year increases in numbers of health complaints, which remains of concern to me.

The Ombudsman in times of Austerity

My office does not operate in isolation from, or without regard to, the continual pressures facing public service providers as a result of budget cuts and public sector reform. These austerity pressures are faced also by my office. Whilst the office, due to its independent status, had not been subject to budgetary reductions in 2014-15, I volunteered a significant budget reduction for 2015-16 and this has subsequently been set at 5%. As a result I have sought to change how my office examines complaints of maladministration by a rigorous assessment process which applies my *Complaints Validation, Investigation and Report Criteria*[3] policy. This has ensured that, where possible, premature complaints are quickly diverted to the body complained of; cases that are amenable to settlement are resolved and only appropriate cases are fully investigated by my office. This shift in focus to robust assessment has resulted in a greater proportion of cases being referred back to the body complained of, thus ensuring that bodies take proper ownership of the complaint and deal directly with the complainant and his/her issues. Also 43% more cases than in 2013-14 have been resolved at assessment stage, allowing investigative resources to be applied to more complex and lengthy investigations. My experience is that the majority of these complex investigations relate to health and social care.

2 See publication: "Alternatives to Court in Northern Ireland" at: http://www.ni-ombudsman.org.uk/Documents/AlternativesToCourt.aspx

3 See publication: "Complaints Validation, Investigation and Report Criteria" at: http://www.ni-ombudsman.org.uk/Documents/Validation-and-Investigation-Criteria-Final-Paper-.aspx

Significant Cases

I wish to highlight the breadth of my jurisdiction in three significant investigations in the reporting year; a health care complaint, a planning complaint and an education-related complaint. I will summarise each case in the following paragraphs.

Care and Treatment of a Cancer Patient

The complainant in this case was dissatisfied with the care and treatment provided to her late husband by the Royal Victoria Hospital (RVH), part of the Belfast Health & Social Care Trust (the Trust). Following an MRI scan, the complainant's husband was diagnosed with a brain tumour and was referred that day to the Neurosurgery Department of the RVH. Unfortunately, the condition of the complainant's husband deteriorated and sadly he died on 1 July 2011. The complainant was unhappy about delays in her late husband's treatment, the failure of the Neuro-Oncology Multi-Disciplinary Team (the MDT), which meets weekly in the RVH, to discuss the case in a timely way and the lack of direct support and personal contact they received from the RVH Neurosurgery team. Although the complainant had written to the RVH on two occasions expressing her concerns about the care and treatment afforded to her husband, the Trust had failed to address those concerns.

My investigation identified serious and multiple failings by the Trust in the care and treatment of the complainant's husband. In particular I found that the Trust failed to ensure that a senior clinician in charge of the complainant's husband's case was fully informed of the policies and procedures of the MDT and about the Trust's management of urgent and deteriorating patients. As a consequence, there was avoidable delay in the decision being made to perform a biopsy and there was also avoidable delay by the RVH Neurosurgery Department in scheduling the biopsy.

My investigation also found a number of other significant failings in care and treatment and in processes; as well as a lack of appropriate support for the patient and his family. However I am pleased to record that the Trust has fully accepted my findings, issued a comprehensive and sincere apology, provided redress to the complainant and her family and agreed to a provide a better service in future to MDT referrals. I will be monitoring the Trust actions in future but I welcome its approach in accepting fully the failings in this case. In addition, through subsequent meetings that both the Trust and the healthcare professionals concerned in her late husband's care have had with the complainant, the case is now being used as a learning tool for clinical staff. I commend this initiative by the Trust to learn from this complaint with a view to improving patient care in the future.

Planning Approach to a Tree Preservation Order

In relation to planning, as in other matters, I have a limited role in that I cannot challenge the merits of a decision taken without maladministration. However I have continued to note failures on the part of DOE Planning and Local Government Group (PLGG) in relation to complaints handling, failure to give adequate reasons and information provided to members of the public about their actions. In this reporting year I investigated a complaint, sponsored by Mr Magennis MLA, by a resident living in a property adjacent to a large tree which was the subject of a temporary and then a permanent Tree Preservation Order (TPO). The focus of my investigation in this case centred on DOE's administrative handling of a request for a provisional TPO which was imposed on a tree adjacent to the complainant's home. It was clear to me that the complainant felt a real sense of injustice, given that the TPO prevented him from undertaking any work in his garden that would affect the health and stability of the tree. However, my investigation did not reveal any evidence of maladministration in relation to DOE's initial decision in December 2012 to make the provisional TPO, which was subsequently confirmed in June 2013. Consequently, I did not uphold this main issue of complaint. While I did note that in this case there were some administrative errors, such as delay in handling

correspondence, for which the department apologised, overall I was content that there was much good practice on the part of the DOE in the decision making process, and I welcome this improvement.

I should also note again that there has been an overall decrease in the number of complaints about DOE PLGG by 26% compared to 2013-14. Also I have noted that the Department is increasingly willing to arrive at a settlement and acknowledge any failings, which illustrates a markedly less defensive attitude to complaints. This is in itself an important factor in building the public's trust in a body's internal complaints process.

Schools Admission Policy

The complainant in this case, sponsored by Lord Morrow MLA, complained about the actions of the Department of Education (the Department) relating to its decision to refuse an additional place for his daughter at a local primary school. The complaint was that there had been a failure by the Department to allocate additional primary school places in a consistent and uniform manner. The Department's policy states that it will not approve additional places at an oversubscribed school when another school of the same type in the area had places available. The Department advised that it was unable to approve an additional place for the new pupil because there were places available at another controlled primary school within travelling distance. The complainant confirmed that the Department did, in fact, allocate an additional eight places to a maintained school which was also oversubscribed despite there being spaces at other schools of the same type within travelling distance.

My investigation found no evidence of maladministration against the Department in relation to the decision to refuse an additional place at the primary school for the complainant's daughter. Neither did my investigation establish maladministration in the grant of eight additional places at a nearby school. I was satisfied that the complainant suffered no injustice as a result of this decision in this regard. However, I could find no reference within any of the Department's policies to 'collateral places', which was an internal process used by the Department to allocate additional places. I considered that this failure to have a written policy on collateral places constituted maladministration. I also identified maladministration in the Department's failure to provide the complainant and his MLA with a full explanation of the collateral places policy from the outset.

I therefore recommended that an explanation of the collateral places policy and how they are applied is included within the relevant Departmental guidance and/or policies. I am pleased to report that the Department has informed me that they have now issued a revised circular which clearly refers to the circumstances that the Department considers may lead to the granting of such places. The Department also informed me that the term 'collateral places' has been changed to 'discretionary place' and in future the Department will inform schools if a pupil has been granted a place under this discretionary measure. I consider that this administrative change will ensure transparency and consistency regarding the Department's approach to school admissions.

The above cases serve to highlight my dual role of providing redress for individuals who sustain injustice and seeking to improve public administration by recommending changes in practice or policies for the benefit of the public at large.

Joint Working Initiatives

A key aspect of serving as an ombudsman or oversight body in the current financial climate is the need to use resources to more effectively deliver oversight of bodies in remit and to ensure that joint and overlapping messages are clear and not contradictory. In last year's annual report I reflected on the joint initiative with the Northern Ireland Human Rights Commission (NIHRC) which built on the Human Rights Principles of Fairness, Respect, Equality, Dignity and Autonomy (FREDA) and in respect of which my staff have received training both internally and from NIHRC. A second product from this joint work is the Human Rights Manual which is a reference tool for my staff. It builds on the expertise

of both organisations to inform staff about building a Human Rights based approach (using FREDA) to investigations of maladministration. This work has been part funded by the International Ombudsman Institute (IOI). I am pleased to record that I launched the manual at their conference in Tallin, Estonia, to much international commendation and support. My and NIHRC staff have now been involved in training other ombudsman's offices in this work which is of both local and international interest. It is my intention to promote and disseminate the learning from this joint working initiative in the next reporting year.

Also, working jointly with the Information Commissioner, in July 2014 I published the *"Good Administration and Good Records Management"* [4] booklet which restates the principles of good administration and adds two new principles focussing on good records management. My staff continued to work during 2014-15 with the ICO's NI Office to train staff across the public sector on these key principles.

Local Government Standards

On 2 June 2014, the jurisdiction of my office was extended to include the investigation and adjudication of complaints under the new mandatory Code of Conduct for Councillors (the Code). My work this year has had a dual focus, in addition to regulating the conduct of councillors against the Code, I have placed considerable effort on promoting the new ethical standards regime. Publication in March 2015 of my Guidance on the Code was central to my work in promoting ethical standards and in ensuring Councillors develop a clear understanding of the behaviour that the Code requires of them. In developing my Guidance I have been able to draw on good practice and case study examples available from other jurisdictions.

My Guidance was also subject to extensive consultation with councillors and other stakeholders to ensure its relevance.

During this first year of this new ethical standards regime, my Office has undertaken a pro-active outreach programme. I delivered a series of presentations, on request, to shadow Councils, councillors and to other stakeholder groups. My staff and I also contributed to a series of NILGA/NAC member development events. This included the delivery of a case study based workshop to provide councillors with real-life examples to consider and discuss with their colleagues. Positive engagement with the Department of the Environment has continued throughout the year. For example, I provided substantive responses to the Department's consultation on both the Code of Conduct and on the Department's Guidance on the Code as it relates to planning matters.

Throughout this year, staff in the Local Government Ethical Standards (LGES) Directorate of my office have developed and are implementing a fair and effective process for investigating complaints. I fully appreciate that LGES investigations, and my adjudication decisions, must be of the highest standard if we are to secure the confidence and trust of the public and the commitment of councillors to the new ethical standards framework.

Looking to the Future

In previous annual reports since 2010 I have recorded progress on the legislation to refresh and reform my office and my role. I am pleased to note that the OFMdFM Committee this year developed and approved the draft Northern Ireland Public Services Ombudsman (NIPSO) Bill which will be introduced into the Assembly early in 2015-16. I am particularly grateful to the Committee Chair, Mr Mike Nesbitt MLA, the Clerk and Assembly Commission staff, in their continued support and commitment to this complex and challenging task. The NIPSO legislation will see a further extension of jurisdiction to include the role of Northern Ireland Judicial Appointments Ombudsman (NIJAO). I also wish to express my gratitude to the current Judicial

4 See publication: "Good Administration and Good Records Management" at: http://www.ni-ombudsman.org.uk/Documents/NI-Ombudsman---ICO-Good-administration-and-good-re.aspx

Appointments Ombudsman, Mr Karamjit Singh CBE and his staff, for their co-operation and also the Chief Executive of the Northern Ireland Judicial Appointments Commission (NIJAC) and staff for information and assistance in developing appropriate working arrangements for the NIPSO office undertaking this important role in the future.

In this reporting year my Office also published research on "*Mapping the Administrative Justice Landscape in Northern Ireland*"[5], clarifying my role as Ombudsman within this complicated and confusing redress maze for the service user.

As my office prepares for the significant legislative change that the NIPSO legislation will bring, I wish to pay tribute to my staff whose commitment and energy have ensured that we continue to provide a valuable contribution to administrative justice in Northern Ireland.

5 See publication: "Mapping the Administrative Justice Landscape in Northern Ireland" at: http://www.ni-ombudsman.org.uk/Documents/electronic-version-of-administrative-justice-repor.aspx

Headline Statistics

Number of Contacts regarding maladministration 2014-15

Written Complaints (Including Electronic Transmission)	–	830
Enquiries - Written	–	340
Enquiries - Telephone	–	1437

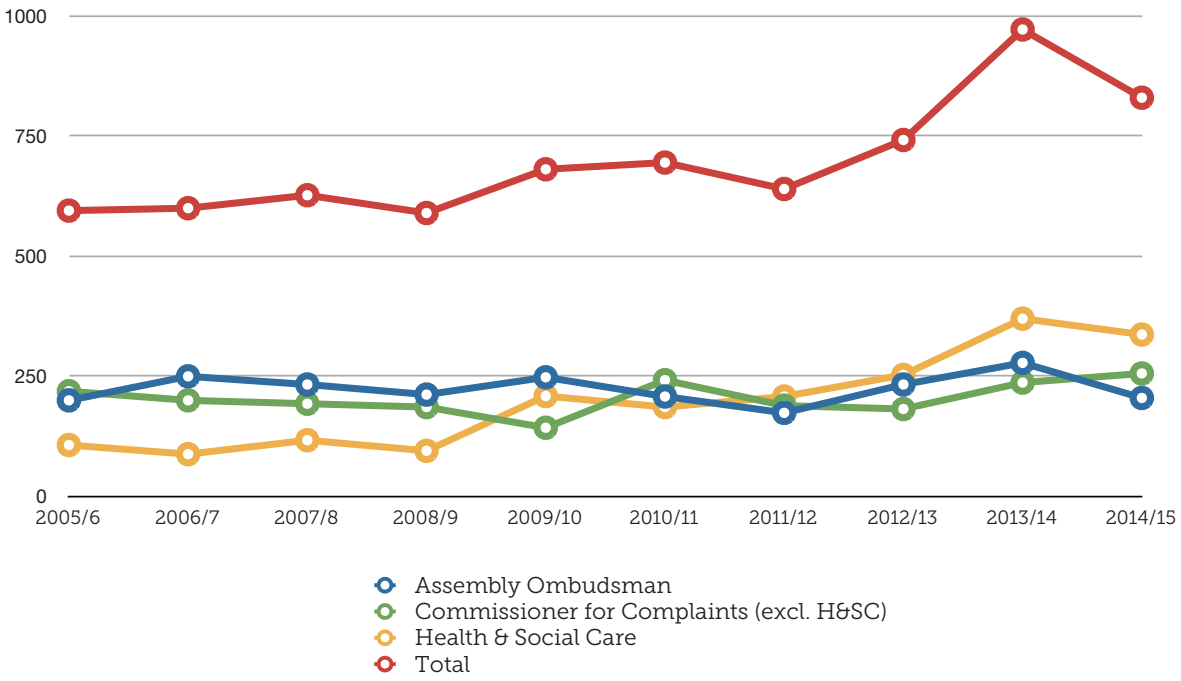
Breakdown of Enquiries to the Office 2014-15

Assembly Ombudsman	–	86
Commissioner for Complaints	–	66
Health and Social Care	–	116
Outside Jurisdiction	–	1509
Total	**–**	**1777**

Breakdown of Written Complaints to the Office 2014-15

Assembly Ombudsman	–	205
Commissioner for Complaints	–	256
Health and Social Care	–	337
Outside Jurisdiction	–	32
Total	**–**	**830**

Complaints Received 2005-06 to 2014-15



Section 2

Advice, Support Service and Initial Screening Team (ASSIST)

Section 2

Advice, Support Service and Initial Screening Team (ASSIST)

In last year's annual report I introduced the front-of-office Advice, Support Service and Initial Screening Team (ASSIST) which was set up in May 2013 as a triage service for all complaints coming into my office. Since its introduction a number of key internal developments and revisions have taken place to further build on the success of the initiative. These have been based upon the themes emanating from analysis of the Office's performance data.

Validation and Investigation Criteria

The above-mentioned revisions have been made against the backdrop of a reduction in our budget; a reality being experienced across the entire public sector. Consequently we have had to closely examine our processes and procedures to ensure that we seize every opportunity to operate in the most efficient and effective ways possible. Whilst the types of complaints we receive are many and varied we are not able and are not required to accept every complaint we receive for investigation. Our focus has therefore been on ensuring we use our resources where we judge them to be most effective. In order to do this fairly, consistently, and transparently we robustly apply our internal "3 Ps" policy[6] of only accepting complaints for investigation where we determine that:

1. An investigation is appropriate and necessary in the circumstances (proportionality), and;
2. An investigation by the Ombudsman would directly bring about a solution or adequate remedy (practical outcome), and;
3. Investigating the issues of complaint could be of potential benefit to the general public (public interest).

In keeping with the proportionality concept we only take up issues where we believe that it is appropriate and necessary. Therefore, if there is no evidence to support the complaint or allegation we may decide that an investigation is not appropriate. Furthermore, in deciding whether a case should be accepted for investigation we focus on the principal and most contentious issues of complaint rather than minor breaches of policy and procedure which have little or no impact on the allegations made.

Complaints Information Leaflets

We have also worked on the literature and communications we have with complainants to ensure a clear understanding of our role and its independence. This emphasises that our role is to decide and inform complainants of what we can and will be investigating, rather than to enter into negotiation regarding the focus of any investigation we may undertake into their stated concerns.

ASSIST is undoubtedly pivotal to the overall performance of the Office as it is within this team that decisions are made as to what can and should be investigated by my Office. Its successful application of the "3 Ps" policy has resulted in a decreased number of cases passing through for investigation, allowing more concentrated effort on completing existing and new investigations within the target timeframes detailed in our key performance indicators.

Settlement of Cases

My current governing legislation grants me discretion to effect a settlement on a case. The establishment of ASSIST has resulted in an increased focus on settlement of cases. This may mean action other than an investigation by my office, albeit that some level of investigation may be warranted so that I might decide what

6 For details of this policy see publication: "Complaints Validation, Investigation and Report Criteria" at: http://www.ni-ombudsman.org.uk/Documents/Validation-and-Investigation-Criteria-Final-Paper-.aspx

constitutes an appropriate settlement in the circumstances of the case. As an alternative to a full investigation of a particular case, culminating in a finding of maladministration and making a recommendation for remedy, settlement is a flexible and speedy alternative approach for providing proportionate and accessible redress for complainants.

Examples of the settlements achieved by ASSIST in 2014-2015 include the payment of £1,062 to a tenant who alleged he had been overcharged unfairly and was paying a higher rental charge than other residents living in his apartment block, following the transfer of the management of his property from one housing association to another. In this case ASSIST was able to secure a full refund of the alleged overpayment within 7 weeks of the complainant having written to my office. Prior to this the complainant had been engaged with Trinity Housing's complaints procedure for approximately 7 months on-and-off and had failed to resolve matters to his satisfaction.

In another case a complainant raised 6 specific issues of complaint relating to the alleged failure of the Northern Ireland Housing Executive (NIHE) to properly investigate a complaint about his neighbour of anti-social behaviour and bullying and the Executive's failure to take appropriate action to resolve this complaint. Within 8 weeks of receiving the complainant's letter asking me to investigate his complaint, ASSIST secured a settlement with the NIHE which resulted in the complainant receiving an apology from the chief executive in recognition of the failure to properly investigate his complaint. As the situation had undoubtedly caused distress and inconvenience for the complainant a payment of £300 also formed part of the settlement proposal. The time taken by ASSIST to conclude this matter by way of settlement compared very favourably to the total of 8 months taken by the body to deal unsuccessfully with the complainant's concerns in the first instance.

Local Resolution

In Health and Social Care (HSC) cases ASSIST may often decide that a case should be returned to the body complained of for further resolution at source as opposed to my accepting the case for investigation at the time it is received. As the complaints I receive about health and social care often represent the most sensitive, complex and challenging cases I deal with, I am careful to ensure that in returning a case for further local resolution there is a real prospect of resolution and that it will not merely result in extending the time taken by the body to deal with the complaint, in effect revisiting the same issues, often with the same outcome. Where ASSIST staff decide to return a case for further local resolution it may be because the body, particularly those central to a complaint, wish to meet with the complainant to discuss their concerns. Given the sensitive, complex and challenging nature of the interactions which take place within the health and social care system, it is my experience that complainants often value such an opportunity as it humanises what can otherwise seem like a very bureaucratic and paper-based complaints process. It is often an opportunity for complainants to receive 'real' acknowledgement of any wrongs that have occurred in their case.

Where a case is returned for further local resolution, ASSIST may decide to outline what areas need to be specifically addressed by the body and/or the format that this should take. However, in order to ensure our independence, we do not oversee the actual process of further local resolution of a case. Rather, the complainant is free to ask me to investigate their complaint once again, in the event that they remain dissatisfied upon completion of this step.

In one such case a family approached my office and asked me to investigate their complaint having spent 9 months in correspondence with the SEHSCT with no prospect of a resolution in sight. Following the intervention of ASSIST, and its observations that the lack of action by the Trust to date evidenced delay and a lack of clarity in the responses issued to the complainants, the Trust provided a further written response to the complainants and agreed to meet with them to discuss specific points of concern. As a result of the meeting the Trust agreed to pay the 'top up fee' that had been applied to their mother's nursing home placement and to make a payment of £3,000 to

cover those payments already made by the complainants in relation to this. The complainants wrote to ASSIST to thank them for their intervention stating that:

> 'we would like to express our sincere gratitude for your intervention up to this point. We do not believe that the outcome to our complaint to the Trust would have been anything like so satisfactory, had it not been for your assistance in securing progress.'

It is notable that following the intervention of my office the Trust was able, within 3 months, to complete further resolution to the satisfaction of the complainant. This demonstrates the importance of local complaint resolution, whereby lessons are learned more effectively and relationships with users/clients can be reestablished and renewed.

Section 3

Annual Report of the Assembly Ombudsman for Northern Ireland

Section 3

Annual Report of the Assembly Ombudsman for Northern Ireland

In my role as **Assembly Ombudsman** I investigate complaints of maladministration against Government departments and their agencies, which are referred to me by MLAs. In 2014-15 I received a total of 205 complaints of maladministration, 26% fewer than in 2013-14. I have commented in Section 1 of this report on the explanation for this drop in the numbers received. As in previous reporting years, the Department which attracted most complaints was the Department of the Environment against which I received a total of 51 complaints, of which 50 related to planning matters. I received a total of 26 complaints against the Department of Finance and Personnel all of which related to Land and Property Services. In all, 38 of the 205 departmental complaints I received in 2014-15 related to agencies of NICS departments.

A common theme running through many of the cases, upon which I made a determination under my Assembly Ombudsman jurisdiction during the reporting year, was that of failures in respect of policies and procedures. The case that follows clearly illustrates this point.

Failure to have a Policy

The complainant in this case, sponsored by Lord Morrow MLA, complained about the actions of the Department of Education (the Department) relating to its decision to refuse an additional place for the daughter of a constituent at a local primary school. The complaint was that there had been a failure by the Department to allocate additional primary school places in a consistent and uniform manner. The Department's policy states that it will not approve additional places at an oversubscribed school when another school of the same type in the area had places available. The Department advised that it was unable to approve an additional place for the new pupil because there were places available at another controlled primary school within travelling distance. The complainant confirmed that the Department did, in fact, allocate an additional eight places to a maintained school which was also oversubscribed despite there being places at other schools of the same type within travelling distance.

My investigation found no evidence of maladministration against the Department in relation to the decision to refuse an additional place at the primary school for the complainant's daughter. Neither did my investigation establish maladministration in the approval of eight additional places at a nearby school. I was satisfied that the complainant suffered no injustice as a result of this decision in this regard. However, I could find no reference within any of the Department's policies to 'collateral places', which was an internal process used by the Department to allocate additional places. I considered that this failure to have a written policy on collateral places constituted maladministration. I also identified maladministration in the Department's failure to provide the complainant and his MLA with a full explanation of the collateral places policy on the reciept of the complaint.

I therefore recommended that an explanation of the collateral places policy and how they are applied is included within the relevant Departmental guidance and/or policies. I am pleased to report that the Department has informed me that they have now issued a revised circular which clearly refers to the circumstances that the Department considers may lead to the granting of such places. The Department also informed me that the term 'collateral places' has been changed to 'discretionary place' and in future the Department will inform schools if a pupil has been granted a place under this discretionary measure. I consider that this administrative change will ensure transparency and consistency regarding the Department's approach to school admissions.

Breadth of Departmental Complaints Cases

My jurisdiction in relation to government Departments is wide ranging and

can include issues relating to the decision-making process as well as employment–related issues, as the following cases illustrate.

A complaint, sponsored by Adrian McQuillan MLA, concerned a Department of Agriculture and Rural Development (DARD) decision that one of the complainant's fields was ineligible for Single Farm Payment (SFP) as it was deemed unfit for grazing. The complainant sought a review of the Department's inspection findings in relation to an on-farm inspection carried out in October 2010. He complained that during the two stages of DARD's Review of Decisions Procedure, the Appeal Officers had difficulty in obtaining information from DARD's Regional Inspector.

The complainant took issue with the Department's contention that there was no evidence to prove that the photographs he had provided of cattle grazing in a field related to the field in question. He also complained that following the Department's decision to set aside an External Panel's recommendation the Department summoned the Head of Countryside Management Unit, the Regional Inspector and an External Panel legal officer to a further meeting to discuss how the Department might defend a potential judicial review.

I arranged for enquiries to be made of DARD's Permanent Secretary, who provided me with additional documentation. Having examined the relevant correspondence, I was satisfied that there was no evidence to suggest that the Appeal Officers had had difficulty in obtaining information from the Regional Inspector.

In relation to the photographs, I noted that they were not dated or clearly labelled. I determined therefore that DARD's contention regarding the photographs was reasonable. I also accepted DARD's explanation that they were not calling into question the complainant's integrity and I was satisfied that there was no evidence to show that a meeting took place between the Head of Countryside Management Unit, the Regional Inspector and an External Panel legal officer. I found no evidence of maladministration in this instance and therefore I did not uphold the complaint.

Inefficiency Sickness Absence Policy

A complaint, sponsored by Mervyn Storey MLA, stated that the Department of Agriculture and Rural Development (DARD) decision to issue a complainant with a written absence warning in July 2013 was unfair as his recent absences had been related to an accident at work and ongoing medical problems. The complainant stated that the written warning was issued solely on the basis of number of days absent and no consideration had been given to the nature of his illness or its cause. Thus he claimed that DARD was failing to apply the policies of the Northern Ireland Civil Service (NICS) Inefficiency Sickness Absence policy.

I arranged for enquiries to be made of the DARD Permanent Secretary who informed me that the complainant had been issued with a written warning following a sickness absence level of thirty four working days. The NICS Inefficiency Sickness Absence policy states that absence will be reviewed after 4 occasions of absence or 10 working days in a rolling 12 month period. An absence lasting 20 consecutive working days or more is classed as long term sickness. The complainant's absence pattern had been such that his sickness level reached both trigger points for it to be considered against the Inefficiency Sicknesss Absence policy.

I found that all of the steps outlined in the NICS policy were followed in the complainant's case. Furthermore, there was clear evidence that DARD had followed NICS policy in terms of considering the required range of factors and the rationale for the decision to issue a written warning was clearly recorded. Having carefully considered the matters raised by the complainant, I was satisfied that DARD did consider the factors presented by the complainant including the nature and cause of his illness. I found no evidence of maladministration in the decision making process to issue a written warning. Such a decision is discretionary and I do not have the power to set aside decisions reached in the course of an appeal process or to revisit issues on which these decisions are based, unless the decision is attended by maladministration. I found no evidence of maladministration in this instance and therefore I did not uphold the complaint.

Complaints Statistics

A detailed breakdown of the number and nature of complaints received under the Assembly Ombudsman jurisdiction is set out below.

Statistical Information – Assembly Ombudsman Cases

Written Complaints Received in 2014-15

There was a total of 205 complaints received during 2014-15, 73 fewer than in 2013-14.

Caseload for 2014-15

Cases Brought Forward at 1 April 2014	43
Written Complaints Received in 2014-15	205
Sub-total	248
Determined at "Can we Investigate?" stage (KPI 1)	152
Determined at "Should we Investigate?" stage (KPI 2)	29
Determined at Full Investigation Stage (KPI 3)	36
Number of Cases Ongoing at 31 March 2015	31

Written Complaints Received in 2014-15 by Authority Type

Agencies of Government Departments	**38**
Government Departments	**140**
North-South Body	**1**
Other Bodies Within Jurisdiction	**26**
Total	**205**

Cases Determined in 2014-15: Analysis of Issues of Complaint

Complaints Handling	**10**
Delay	**2**
Enforcement/ Legal Action	**8**
Policy and Procedures	**103**
Staff Attitude and Behaviour	**5**
Other	**85**
Total	**213**

Note: Number of Issues of Complaint will not equate to the number of cases as some cases will raise multiple issues. Also, owing to timing issues, cases determined in any given year will not equate to the number of new cases received in that year.

Recommendations in Reported and Settled Cases 2014-15

Case No	Body	Recommendation
13799	Department of the Environment - Planning and Local Government Group	Apology, payment of £1,250
14126	Department of the Environment - Planning and Local Government Group	Apology, payment of £300
14132	Department of the Environment - Planning and Local Government Group	Apology
14339	Department of Education	Service Improvement
14665	Department of the Environment - Planning and Local Government Group	Apology, payment of £750
15010	Department of Finance & Personnel - Land & Property Services	Rates reduction, extended repayment period
15025	Department of the Environment - Planning and Local Government Group	Payment of £500
15052	Department of Finance & Personnel - Land & Property Services	Reduction of Capital Value from £155,000 to £145,000; payment of £200, extended repayment period
15193	Department of the Environment - Planning and Local Government Group	Payment of £1,806
15208	Department of Finance & Personnel - Land & Property Services	Extended repayment period
15592	Department of Finance & Personnel - Land & Property Services	Rates reduction, extended repayment period

Analysis of Written Complaints Determined in 2014-15

	Brought Forward @ 1/4/14	Complaints Received in 2014-15	Determined at KPI* 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/15
Agencies of Government Departments	3	38	32	6	2	1
Government Departments	35	140	100	22	28	25
North-South Body	0	1	1	0	0	0
Other Bodies Within Jurisdiction	5	26	19	1	6	5
Total	43	205	152	29	36	31

***** For explanations of "KPIs" see **Appendix C**

Analysis of Written Complaints against Agencies

	Brought Forward @ 1/4/14	Complaints Received in 2014-15	Determined at KPI 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/15
Driver & Vehicle Agency	0	11	10	0	0	1
Northern Ireland Environment Agency	1	4	3	2	0	0
Rivers Agency	1	1	1	0	1	0
Roads Service	0	7	6	1	0	0
Social Security Agency	1	15	12	3	1	0
Total	3	38	32	6	2	1

Analysis of Written Complaints against Government Departments

	Brought Forward @ 1/4/14	Complaints Received in 2014-15	Determined at KPI 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/15
DRD	0	2	2	0	0	0
DSD	2	8	7	3	0	0
DSD – CMS	0	14	11	0	2	1
DARD	3	13	12	0	3	1
DCAL	1	8	8	0	1	0
DE	4	1	1	1	2	1
DEL	1	3	2	1	1	0
DETI	1	3	3	0	0	1
DFP	0	2	2	0	0	0
DFP – LPS	5	26	16	4	6	5
DHSSPS	0	1	1	0	0	0
DOJ	0	3	3	0	0	0
DOJ – NICTS	0	3	3	0	0	0
DOE	1	1	2	0	0	0
DOE – PLGG	17	50	27	13	12	15
OFMdFM	0	2	0	0	1	1
Total	35	140	100	22	28	25

Analysis of Written Complaints against North-South Bodies

	Brought Forward @ 1/4/14	Complaints Received in 2014-15	Determined at KPI 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/15
Special European Union Programmes Body	0	1	1	0	0	0
Total	0	1	1	0	0	0

Analysis of Written Complaints against Other Bodies within Jurisdiction

	Brought Forward @ 1/4/14	Complaints Received in 2014-15	Determined at KPI 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/15
Appeals Service	0	3	3	0	0	0
Industrial Tribunal	0	2	1	0	1	0
Northern Ireland Courts & Tribunals Service	1	9	8	1	1	0
Northern Ireland Prison Service	4	9	5	0	4	4
Not Specified AO Body	0	1	1	0	0	0
Planning Appeals Commission	0	1	0	0	0	1
Prisoner Ombudsman for Northern Ireland	0	1	1	0	0	0
Total	5	26	19	1	6	5

Section 4

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

Section 4

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

As **Commissioner of Complaints** I have a wide remit in Northern Ireland. In this role I can investigate complaints about local councils, the Housing Executive, registered housing associations, and the education and justice sectors, in addition to a wide range of other specific public bodies. A significant number of complaints made relate to health and social care matters. Details of these cases can be found in Section 5 of this report.

I have reported a decrease this year in complaints received across my jurisdictions, which is reflected in the numbers of complaints received about health and social care and Government departments. However this trend is not reflected in the number of complaints about bodies which come under the remainder of my jurisdiction as Commissioner. My office has experienced an increase of 8% in such complaints. Of particular note is a 21% rise in complaints about the actions or omissions of Local Councils. This is the second successive year that complaints in Local Government have increased.

The New Councils

The new Council structures have been established with full effect from April 2015. These Councils will have enhanced powers and decision making at local community level which have the potential to significantly affect the lives of citizens. Whilst Councils, in their previous form, against whom complaints have been made to my office may not any longer exist in their own right, at the time that I issue my report into a particular complaint, responsibility for the legacy complaints and for any maladministration as a result of the actions of the previous Council and any improvements to services to be implemented as a result, will fall to the newly established so-called 'Super Councils'. It is my expectation that my recommendations and any learning from complaints will be used by the new successor Councils to improve services.

Larne Borough Council

A recent case against Larne Borough Council highlights the need for bodies to ensure clarity and consistency in how they procure services. In this case I found that the Council had failed in its decision making process in a number of respects relating to an external bid by way of an Expression of Interest (EoI) project for Carnfunnock Country Park. My investigation identified maladministration in the Council's handling of the EoI process. In particular I found that the overall delay in the process was unreasonable and avoidable. I also found that the tendering process that followed lacked clarity and the approach adopted was inconsistent. In addition to improvements in complaints handling and in how the Council deals with correspondence, I recommended that specific action should be taken to ensure clear and appropriate procedures are in place for any future EoI exercises. The lessons learned from this complaint are of relevance to the new Council (Mid and East Antrim) as it seeks to ensure that the procedures which underpin procurement going forward are robust, clear and in compliance with good practice.

I completed a second investigation into a complaint against Larne Borough Council following which I did not uphold the complaint. The complainant in this case alleged an abuse of power by the then Chief Executive of the Council in relation to delay in issuing lease documents, the need for him to resign as a director of a community based association and the Council's handling of a complaint he made to it in February 2012. Having completed a detailed investigation of this complaint, I found no evidence of maladministration on the part of the Council in relation to its handling of the issue of the lease documents in this case. Nor did I find

evidence of maladministration in the advice the Council provided in relation to good governance, accountability, good practice and transparency which led to the complainant resigning from the positions he held in two community based associations. Similarly, I found no evidence of maladministration by the Council in its complaint handling in this case.

Ballymoney Borough Council

I can investigate employment-related complaints from staff of bodies within my jurisdiction. A recent complaint against Ballymoney Borough Council (the Council) illustrated the importance of my role in seeking to effect a settlement of such a complaint, in providing swift resolution of the matter and in safeguarding my limited resources for other more intractable complaints. I am pleased to say this case also demonstrated the value and importance of constructive engagement by the body complained of in its willingness to re-consider a complaint with an open mind and acknowledge its failings. The complainant in this case complained about the actions of the Council in that he was denied a full time post after being ranked first on a reserve list and accepting a part time post whilst waiting on a permanent full time post. He also complained that there was undue delay in responding to his MLA's enquiries

In his response to my enquiries, the Chief Executive advised that both aspects of this complaint were well founded. In light of this, the Chief Executive proposed settlement of the complaint by the offer of a permanent full time post and the calculation of any financial loss to the complainant as result of the failure to offer him a full time post in September 2013, including any additional salary and pension contribution. The Head of Human Resources also reviewed the Council's policy and practice in relation to the operation of the reserve list. Future changes to avoid a recurrence of this complaint were proposed to ensure that candidates are fully informed about the operation of the reserve list. In this case I regarded the proposal of the Council to be a satisfactory remedy for its failings and exercised my discretion to accept this settlement and discontinue my investigation. I was later informed by the Council that the complainant took up his post in October 2014.

Northern Ireland Fire and Rescue Service

I also investigated a complaint against the Northern Ireland Fire and Rescue Service (NIFRS), which highlighted the need for clarity in relation to employment matters. The crux of the complaint was that the complainant failed to be shortlisted for the post of Whole time/Retained Firefighter. The NIFRS explained to the complainant that he was not shortlisted because he had failed to demonstrate how he was able to meet the shortlisting criterion that specified that an applicant could not hold other employment at the closing date for applications. The complainant said that this requirement was not explained to applicants nor was it fair. The complainant had indicated on his application form that he had other employment from which he would resign if successful in his application. However, the NIFRS expected applicants to resign from such employment before a definite offer of employment with NIFRS was made.

Following my investigation, whilst I acknowledged the particular circumstances relating to employment of retained firefighters, I concluded that there was; a lack of clarity in the application documentation; failure to advise applicants that the shortlisting criteria must be met at closing date for applications; and failure to shortlist the complainant. I recommended that the complainant receive an apology; that the NIFRS review its application documentation for all future competitions to ensure compliance with good selection practice; and that the NIFRS issue guidance regarding the shortlisting methodology to those eligible to participate as panel members in recruitment competitions.

Complaints about Social Housing

I also continue to receive complaints about the social housing sector; these are wide ranging and relate to a range of issues including maintenance, arrears, housing allocation, housing benefit, anti-social behaviour and adaptations

for disabled people. Maintenance and repairs and housing allocation were again the most common areas of complaint in 2014-15. This year complaints about housing bodies overall have decreased by 7%. Within this overall reduction, complaints of maladministration against the NIHE have decreased by 17%, whereas complaints against housing associations have increased by 14%.

Complaints Statistics

The statistical information below reflects the number of complaints received in my Commissioner for Complaints role in 2014-15 and how they have been determined by my Office.

Statistical Information – Commissioner for Complaints Cases (other than Health and Social Care)

Written Complaints Received in 2014-15

A total of 256 complaints were received during 2014-15, 19 more than in 2013-14.

Caseload for 2014-15

Cases Brought Forward at 1 April 2014	40
Written Complaints Received in 2014-15	256
Sub-total	296
Determined at "Can we Investigate?" stage (KPI 1)	201
Determined at "Should we Investigate?" stage (KPI 2)	41
Determined at Full Investigation Stage (KPI 3)	33
Number of Cases Ongoing at 31 March 2015	21

Written Complaints Received in 2014-15 by Authority Type

Education Authority	**25**
Health & Social Care Bodies*	**25**
Housing Bodies	**81**
Local Councils	**85**
Other CC	**40**
Total	**256**

* Note that this relates to complaints about HSC bodies **other than** in relation to clinical care and treatment.

Cases Determined in 2014-15: Analysis of Issues of Complaint

	Total
Complaints Handling	**20**
Delay	**2**
Enforcement/ Legal Action	**1**
Out of Jurisdiction	**4**
Policy and Procedures	**125**
Social Care and Treatment	**1**
Staff Attitude and Behaviour	**5**
Other	**118**
Total	**276**

Note: Number of Issues of Complaint will not equate to the number of cases as some cases will raise multiple issues. Also, owing to timing issues, cases determined in any given year will not equate to the number of new cases received in that year.

Recommendations in Reported and Settled Cases 2014-15

Case No	Body	Recommendation
13307	Larne Borough Council	Apology
13633	Belfast Education and Library Board	Apology & Service Improvement
13722	North Eastern Education & Library Board	Apology & Service Improvement
13723	Belfast Education and Library Board	Apology & Service Improvement
13789	Arts Council	Apology & Service Improvement
13821	Lisburn City Council	Apology
14203	Northern Ireland Fire and Rescue Service	Apology & Service Improvement
14249	Coleraine Borough Council	Apology
14476	Coleraine Borough Council	Apology
14722	Down District Council	Payment of £180
14814	Oaklee Homes Group	Apology & Service Improvement
15464	Fold Housing Association	Payment of £100
15488	Northern Ireland Housing Executive	Apology, payment of £300
15489	Trinity Housing	Payment of £1,062
201100024	Belfast Health & Social Care Trust	Apology
201100025	Belfast Health & Social Care Trust	Apology & Service Improvement
201100999	Derry City Council	Apology. Payment of £500.

Analysis of Written Complaints Determined in 2014-15

	Brought Forward @ 1/4/14	Complaints Received in 2014-15	Determined at KPI* 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/15
Education Authority	5	25	21	2	5	2
Health & Social Care Bodies	4	25	15	8	5	1
Housing Bodies	8	81	68	10	8	3
Local Councils	16	85	62	19	10	10
Other Bodies Within Jurisdiction	7	40	35	2	5	5
Total	40	256	201	41	33	21

* For explanations of "KPIs" see **Appendix C**

Analysis of Written Complaints about Education Authorities

	Brought Forward @ 1/4/14	Complaints Received in 2014-15	Determined at KPI 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/15
Belfast Education & Library Board	2	0	0	0	2	0
Council for Catholic Maintained Schools	0	1	1	0	0	0
Council for the Curriculum, Examinations & Assessment	0	1	1	0	0	0
North Eastern Education & Library Board	1	3	2	1	1	0
South Eastern Education & Library Board	0	6	6	0	0	0
Southern Education & Library Board	2	6	4	1	2	1
Western Education & Library Board	0	8	7	0	0	1
Total	5	25	21	2	5	2

Analysis of Written Complaints about Health and Social Care Bodies (on matters other than Clinical Care and Treatment)

	Brought Forward @ 1/4/14	Complaints Received in 2014-15	Determined at KPI 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/15
Belfast Health & Social Care Trust	1	6	4	1	2	0
Business Services Organisation	0	5	3	2	0	0
Northern Health & Social Care Trust	1	5	3	2	1	0
South Eastern Health & Social Care Trust	1	4	1	1	2	1
Southern Health & Social Care Trust	1	3	2	2	0	0
Western Health & Social Care Trust	0	2	2	0	0	0
Total	4	25	15	8	5	1

Analysis of Written Complaints about Housing Authorities

	Brought Forward @ 1/4/14	Complaints Received in 2014-15	Determined at KPI 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/15
Belfast Community Housing Association Ltd	0	1	1	0	0	0
Clanmil Housing Association Ltd	0	2	2	0	0	0
Connswater Homes Ltd	1	4	4	0	1	0
Fold Housing Association	0	9	5	2	1	1
HELM Housing	1	5	5	1	0	0
Northern Ireland Housing Executive	4	49	42	6	3	2
Oaklee Homes Group	1	6	5	0	2	0
Rural Housing Association Ltd	0	1	1	0	0	0

South Ulster Housing Association Ltd	1	1	2	0	0	0
Trinity Housing	0	3	1	1	1	0
Total	8	81	68	10	8	3

Analysis of Written Complaints about Local Councils

	Brought Forward @ 1/4/14	Complaints Received in 2014-15	Determined at KPI 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/15
Antrim Borough Council	0	1	1	0	0	0
Ards Borough Council	1	1	1	1	0	0
Armagh City & District Council	0	6	4	2	0	0
Ballymena Borough Council	0	5	5	0	0	0
Ballymoney Borough Council	0	3	1	1	1	0
Banbridge District Council	0	7	4	3	0	0
Belfast City Council	1	7	3	5	0	0
Castlereagh Borough Council	0	1	1	0	0	0
Coleraine Borough Council	2	2	1	0	2	1
Cookstown District Council	1	3	3	0	1	0
Craigavon Borough Council	3	14	9	2	1	5
Derry City Council	0	4	4	0	0	0
Down District Council	2	8	5	2	2	1
Dungannon & South Tyrone Borough Council	0	2	2	0	0	0
Fermanagh District Council	0	1	1	0	0	0
Larne Borough Council	2	2	1	1	2	0

Limavady Borough Council	1	1	0	1	0	1
Lisburn City Council	1	2	2	0	1	0
Magherafelt District Council	0	3	3	0	0	0
Newry & Mourne District Council	2	0	1	0	0	1
Newtownabbey Borough Council	0	2	2	0	0	0
North Down Borough Council	0	5	4	1	0	0
Omagh District Council	0	5	4	0	0	1
Total	16	85	62	19	10	10

Analysis of Written Complaints about Other Bodies within Jurisdiction

	Brought Forward @ 1/4/14	Complaints Received in 2014-15	Determined at KPI 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/15
ARC21	0	1	1	0	0	0
Arts Council	2	0	0	0	1	1
Charity Commission for Northern Ireland	0	8	7	0	1	0
Consumer Council	0	2	2	0	0	0
Equality Commission for Northern Ireland	1	0	0	0	0	1
Invest NI	0	5	4	0	1	0
Labour Relations Agency	1	2	3	0	0	0
Local Government Staff Commission	0	1	1	0	0	0
Northern Ireland Fire and Rescue Service	2	6	5	1	1	1
Northern Ireland Law Commission	0	1	1	0	0	0

Northern Ireland Legal Services Commission	1	1	0	0	1	1
Northern Ireland Policing Board	0	5	5	0	0	0
Northern Ireland Social Care Council	0	1	1	0	0	0
Probation Board for Northern Ireland	0	7	5	1	0	1
Total	7	40	35	2	5	5

Section 5

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

Section 5

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

Health and social care (HSC) complaints continue to be the most significant area of casework for my Office. The total number of new HSC complaints in 2014-15 reduced slightly from the high of 370 reported in 2013-14 to 337, a reduction of 9%. However the general trend in HSC complaints remains upwards with the number having increased by 81% over the last five years. In 2014-15 complaints related to HSC represented 41% of the total complaints received by my Office; in 2013-14 this proportion was 38%.

HSC Complaints Statistics

Of the 337 HSC cases received this year, 50 (15%) were accepted for investigation. In keeping with previous years a large number of HSC-related complaints continue to be received by my office before the complainant has raised the issues with the relevant HSC body and/or before they have been fully considered by that body under the HSC complaints procedure. In 2014-15 approximately one third (34%) of HSC cases were closed by my office on these grounds, with a further 21% of cases being closed due to insufficient information being provided by the complainant about their complaint.

It is often the case that individual complainants bring a number of issues to me which they wish me to investigate. During 2014-15 I made a determination on 78 issues of complaint which complainants brought to me in my HSC jurisdiction. I upheld 71% of these issues of complaint.

All HSC organisations follow a single stage statutory complaints procedure, which seeks to ensure that complaints are resolved at a local level. The statutory guidelines for dealing with HSC complaints provide a useful framework. It is however essential that HSC organisations use the guidelines appropriately and rigorously investigate the issues of complaint brought by patients/users of HSC services or their families. Frequently there are unacceptable delays in providing detailed responses to complaints and in some cases the rigour applied in investigating complaints is not sufficient. By virtue of being an office of last resort and the process that I use to decide on which cases to accept for investigation, many of the complaints I accept for investigation are challenging and relatively intractable. An underlying issue in many of these complaints is the breakdown in trust between the patient/family and the HSC body. Independence and fairness are fundamental to my role. The Human Rights values of Fairness, Respect, Equality, Dignity and Autonomy are very important in dealing with what can be very complex and challenging HSC issues.

The Patient Experience

In our modern HSC system a patient journey may involve a number of HSC bodies. Therefore it is important that the HSC system is designed so that essential information is available at each stage of a patient's journey, thus ensuring appropriate care and treatment. Increasingly HSC bodies will agree to a composite report where a complaint relates to more than one HSC body. This approach to investigation and reporting is in my view more reflective of the patient experience and of HSC service delivery and allows for a greater understanding of the issues and of the care pathway.

As in 2013-14 the main HSC issue of complaint made to me in this year was clinical and social care and treatment; which represented 62% of the HSC issues determined by me during the reporting year. However it remains of concern to me that complaint handling by HSC bodies continues to feature highly among the issues of concern brought to me. The fact that all but one of the issues of complaint brought to me about complaint handling were upheld at detailed investigation stage

indicates that HSC bodies need to do more to ensure that they have a rigorous and efficient complaints handling process.

The importance of providing complainants with comprehensive responses which directly answer all of the issues raised within a complaint cannot be overstated. HSC bodies need to investigate complaints from the public in an open and transparent way. Being evasive or defensive, and not properly addressing issues of complaint, breeds a sense of suspicion and mistrust which prolongs the complaints process, leading to further frustration and distress and the likelihood that local resolution will not be successful. I continue to urge HSC bodies to focus on providing complainants with open, full and complete responses, which are properly considered. A response to a complainant should address all of the concerns raised by the patient or family member, with all necessary reasons for decisions expressed in clear language so as to aid understanding. A 'complainant centred' approach will help to ensure that complainants get the answers they are seeking to all their issues of concern at source.

Records Management

While often not an issue raised with me by complainants, poor record keeping by HSC bodies remains an issue which is commonly identified during my investigations. While acknowledging the demands placed on health care professionals, good record keeping must form an essential part of their practice and is a requirement under both Nursing and Midwifery Council and General Medical Council guidance. Poor record keeping has the potential to have a significantly detrimental impact on patient care. In July 2014 I launched, with the Information Commissioner, a booklet on *"Good Administration and Good Records Management"*[7] and a number of workshops were delivered focussing on HSC issues.

Clear communication between those involved in a patients care and the patient and/or their family is also an important element in determining how individuals view the quality of care provided to them or their loved ones. A lack of clear communication was evident in a number of complaints which I reported on during the year. I would urge those involved in providing care to ensure accurate and timely communication with patients and or their families as doing so can assist in reducing distress and uncertainty at difficult and stressful times.

Complaints Statistics

The statistical information overleaf reflects the number of health and social care complaints received in 2014-15 and how they have been determined by my Office.

7 See publication: "Good Administration and Good Records Management" at: http://www.ni-ombudsman.org.uk/Documents/NI-Ombudsman---ICO-Good-administration-and-good-re.aspx

Statistical Information – Commissioner for Complaints Cases - Health and Social Care

Written Complaints Received in 2014-15

A total of 337 complaints were received during 2014-15, 33 fewer than in 2013-14.

HSC Caseload for 2014-15

Cases Brought Forward at 1 April 2014	114
Written Complaints Received in 2014-15	337
Sub-total	451
Determined at "Can we Investigate?" stage (KPI 1)	249
Determined at "Should we Investigate?" stage (KPI 2)	39
Determined at Full Investigation Stage (KPI 3)	74
Number of Cases Ongoing at 31 March 2015	89

Written Complaints received in 2013/14 by Authority Type

Health & Social Care Board	**3**
Health & Social Care Trusts	**288**
Other Health & Social Care Bodies	**46**
Total	**337**

Cases Determined in 2014-15: Analysis of Issues of Complaint

	Total
Clinical Care and Treatment	**224**
Complaints Handling	**41**
Delay	**7**
Other	**52**
Out of Jurisdiction	**1**
Policy and Procedures	**57**
Social Care and Treatment	**61**
Staff Attitude and Behaviour	**19**
Total	**462**

Note: Number of Issues of Complaint will not equate to the number of cases as some cases will raise multiple issues. Also, owing to timing issues, cases determined in any given year will not equate to the number of new cases received in that year.

Recommendations in Reported and Settled Cases 2014-15

Case No	Body	Recommendation
13165	Belfast Health & Social Care Trust	Apology
13278	Northern Health & Social Care Trust	Apology & Service Improvement
13283	Belfast Health & Social Care Trust	Apology & Service Improvement
13290	Belfast Health & Social Care Trust	Apology
13319	Southern Health & Social Care Trust	Apology & Service Improvement
13320	Belfast Health & Social Care Trust	Apology
13408	Health Service Providers - GP	Apology & Service Improvement
13437	Health Service Providers - GP	Apology & Service Improvement
13438	Belfast Health & Social Care Trust	Apology & Service Improvement
13495	Western Health & Social Care Trust	Apology & Service Improvement
13565	Belfast Health & Social Care Trust	Apology & Service Improvement
13618	Western Health & Social Care Trust	Apology & Service Improvement
13695	Health & Social Care Board	Apology & Service Improvement
13738	Western Health & Social Care Trust	Apology & Service Improvement
13839	Northern Health & Social Care Trust	Apology
13868	Southern Health & Social Care Trust	Apology & Service Improvement
13881	Health Service Providers - GP	Apology
13939	Health Service Providers - GP	Apology & Service Improvement
13996	South Eastern Health & Social Care Trust	Apology & Service Improvement
14017	Southern Health & Social Care Trust	Apology & Service Improvement
14060	Southern Health & Social Care Trust	Apology & Service Improvement
14128	South Eastern Health & Social Care Trust	Apology & Service Improvement
14185	Southern Health & Social Care Trust	Apology & Service Improvement
14186	Southern Health & Social Care Trust	Apology & Service Improvement
14248	Health Service Providers - GP	Apology
14279	Northern Health & Social Care Trust	Apology & Service Improvement
14301	Northern Health & Social Care Trust	Apology & Service Improvement
14325	Health Service Providers - GP	Apology & Service Improvement
14330	South Eastern Health & Social Care Trust	Apology
14365	South Eastern Health & Social Care Trust	Apology & Service Improvement
14379	Independent HSC Provider	Apology, reduction of money owed by £300
14466	South Eastern Health & Social Care Trust	Apology & Service Improvement
14578	Northern Health & Social Care Trust	Apology & Service Improvement
14743	South Eastern Health & Social Care Trust	Apology & Service Improvement
14750	Belfast Health & Social Care Trust	Apology
14768	Belfast Health & Social Care Trust	Apology
15017	Northern Ireland Ambulance Service Trust	Apology

15054	Northern Health & Social Care Trust	Apology, offer to reimburse damage to equipment
15206	South Eastern Health & Social Care Trust	Apology
201000728	Belfast Health & Social Care Trust	Apology & Service Improvement
201100282	Belfast Health & Social Care Trust	Apology
201100876	Western Health & Social Care Trust	Apology & Service Improvement

Analysis of Written Complaints Determined in 2014-15

	Brought Forward @ 1/4/14	Complaints Received in 2014-15	Determined at KPI* 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/15
Health & Social Care Trusts	86	288	210	36	58	70
Health & Social Care Board	3	3	2	0	2	2
Other Health & Social Services Bodies	25	46	37	3	14	17
Total	114	337	249	39	74	89

* For explanations of "KPIs" see **Appendix C**

Analysis of Written Complaints against Health & Social Care Trusts

	Brought Forward @ 1/4/14	Complaints Received in 2014-15	Determined at KPI 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/15
Belfast Health & Social Care Trust	28	60	45	10	20	13
Northern Health & Social Care Trust	11	34	23	5	8	9
Northern Ireland Ambulance Service Trust	2	15	11	3	1	2
South Eastern Health & Social Care Trust	15	56	34	11	12	14
South Eastern Health & Social Care Trust (Prison Healthcare)	1	19	17	1	0	2

Southern Health & Social Care Trust	19	37	30	2	10	14
Western Health & Social Care Trust	10	67	50	4	7	16
Total	86	288	210	36	58	70

Analysis of Written Complaints against Health & Social Care Board

	Brought Forward @ 1/4/14	Complaints Received in 2014-15	Determined at KPI 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/15
Health & Social Care Board	3	3	2	0	2	2
Total	3	3	2	0	2	2

Analysis of Written Complaints against Other Health and Social Care Bodies

	Brought Forward @ 1/4/14	Complaints Received in 2014-15	Determined at KPI 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/15
Business Services Organisation	1	0	0	0	1	0
Health Service Providers - GDP	5	1	2	2	0	2
Health Service Providers - GP	13	31	24	0	12	8
Independent HSC Provider	2	2	1	0	1	2
Independent HSC Provider - Out of Hours GP Services	1	0	0	0	0	1
Independent HSC Provider - Private Nursing Home	3	2	2	0	0	3
Not Specified HC Body	0	3	3	0	0	0
Regulation and Quality Improvement Authority	0	7	5	1	0	1
Total	25	46	37	3	14	17

Section 6

Annual Report of the Northern Ireland Commissioner - Local Government Ethical Standards

Section 6

Annual Report of the Northern Ireland Commissioner for Complaints - Local Government Ethical Standards

In my role as Northern Ireland Commissioner for Complaints, I am responsible for investigating and adjudicating on written complaints that councillors have breached the Northern Ireland Local Government Code of Conduct for Councillors (the Code). In 2014-15 I received 14 complaints, which in total alleged 26 breaches of the Code. The majority of these related to allegations that councillors had failed to meet their obligations as a councillor (11 instances) and/or had failed to show respect and consideration for others (8 instances).

The Commissioner's Guidance on the Code of Conduct for Councillors

The Local Government Act (NI) 2014 (Article 54) gives me the power to "issue guidance on matters relating to the conduct of councillors and arrange for the guidance to be made public." I consulted extensively with all stakeholders directly affected by the introduction of the Code before launching my Guidance on 20 March 2015, in advance of the transfer of powers to the new councils on 1 April 2015. The Guidance is intended to help councillors understanding of the Code and the obligations it places on them. The Guidance provides an overview of the role of my Office, and explains what councillors can expect in terms of assessment, investigation and adjudication processes should they be the subject of a complaint. The Guidance also makes extensive use of case study examples from other jurisdictions. It is my intention in future, as a body of my decisions develops in Northern Ireland, to provide local examples that will support this guidance and provide clarity on the Code for Councillors and the public. I would take this opportunity to thank the contributors to this guidance, in particular the Irish and Welsh Ombudsmen.

Engagement with Key Stakeholders

During 2014-15, my Office engaged widely with stakeholders to promote understanding of the Code and its requirements. I delivered a series of presentations to the shadow councils for Lisburn and Castlereagh, Newry Mourne and Down, North Down and Ards, Mid-Ulster, and Mid and East Antrim. I also spoke at Northern Ireland Local Government Association (NILGA) awareness events in Cookstown and Belfast and at the Society of Local Authority Chief Executives (SOLACE) NI Branch Forum. My Deputy and I, supported by her team in the Local Government Ethical Standards (LGES) Directorate, contributed to a series of NILGA member development events in Craigavon, Newtownabbey and Omagh. A case study based workshop was developed to provide councillors with real-life examples to consider and discuss with colleagues. My office has also engaged extensively with senior representatives from oversight bodies which have regulatory roles and with other regulatory bodies. These include the Local Government Auditor, the Human Rights Commissioner, the Director of Public Prosecutions and the Solicitors Disciplinary Tribunal. These contacts identified the need for Memoranda of Understanding to be developed between my Office and the Local Government Auditor, other such memoranda may follow. My Office has engaged extensively with DOE in matters relating to ethical standards: providing detailed responses to DOE's consultation on the Code of Conduct

and on the Department's Guidance on Part 9 of the Code (Planning Matters).

Introduction of Public Interest Considerations

In deciding whether to investigate a complaint or to continue an investigation to the stage of referring the complaint for adjudication, a key consideration for my Office is whether an investigation would be in the public interest. Testing the public interest considerations in each case not only ensures that the limited resources of my Office are directed towards the most serious breaches of the Code: it also protects councillors against frivolous, trivial and vexatious complaints. A consideration of the public interest requires my staff to examine the seriousness of the alleged breach and whether a decision to investigate is a proportionate response to the conduct complained of. The likely cost of an investigation, and any adjudication, is also a relevant consideration, especially where the cost could be regarded as excessive when weighed against any likely sanction. I intend in the coming year to draw up guidance on the public interest considerations for use by staff in the assessment of complaints and to make this guidance publicly available.

The Review of the Code of Conduct for the Northern Ireland Assembly

The Code of Conduct for Councillors is founded on the principles adopted by the Northern Ireland Assembly in its own Code of Conduct: the seven Nolan principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership; and the five additional principles adopted by the Assembly of public duty, equality, promoting good relations, respect and good working relationships. The Assembly's Committee on Standards and Privileges is, at present, concluding a review of the Assembly's Code of Conduct. On 27 May 2014 the Minister for the Environment, Mark H Durkan MLA, undertook to reconsider the principles set out in the Local Government Code of Conduct on the foot of the Assembly's review and, if necessary, to bring a revised Local Government Code to the Assembly at a future date. I have assured the Minister of my willingness to participate fully in any future review of the Code.

Action instead of or in addition to an investigation – minor complaints

The 2014 Act provides my Office with the authority to take action instead of, or in addition to, conducting an investigation, to deal with an alleged breach of the Code.

Action **instead** of an investigation may be appropriate where:

- there is no public interest in undertaking an investigation; or
- there is an alternative mechanism to deal with the complaint (such as any council procedure for dealing with a complaint from a council officer about a councillor's conduct).

Action in **addition** to an investigation may be appropriate where:

- it would be appropriate to recommend that the complainant and the councillor undertake mediation or conciliation; or
- it is considered that the councillor should be offered training on the Code; or
- an apology is an appropriate and proportionate response in the particular case.

DOE is currently developing options for handling minor complaints through action instead of or in addition to an investigation. I will be contributing fully to the consideration of other options for alternative complaint resolution proposed by DOE.

Statistical Information

Caseload for 2014-15

Enquires (not resulting in a complaint)	4
Written Complaints Received	14
Number determined at Initial Assessment	3
Number determined at Assessment Stage	2
Number determined at Investigation Stage	0
Number of Complaints Ongoing at 31/3/15	9

Written Complaints Received by Council

Antrim and Newtownabbey	2
Mid and East Antrim	3
Ards and North Down	0
Armagh, Banbridge and Craigavon	4
Belfast	1
Causeway Coast and Glens	0
Derry and Strabane	2
Fermanagh and Omagh	0
Mid Ulster	0
Newry, Mourne and Down	2
North Down and Ards	0
Lisburn and Castlereagh	0
Total	14

Basis of Complaint*

Obligations as a Councillor this includes requirements to act lawfully and not to bring the position of councillor or the council into disrepute	11
Behaviour towards other people this includes a requirement to show respect and consideration for others	8
Use of Position this includes a requirement not to use the position of councillor to secure an advantage for oneself	1
Disclosure of Information this includes a requirement not to disclose confidential information	3
Decision-making this includes the requirement to reach decisions objectively, on the basis of the merits of the circumstances involved, and in the public interest	3
Total	26

*includes valid complaints only. The total is greater than 14 as a number of complaints refer to more than one alleged breach

Appendices

Appendix A

Principles of Good Administration

Principles of Good Administration [Source: Parliamentary and Health Service Ombudsman]

Good administration by public bodies means:

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

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

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

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

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

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

These Principles are not a checklist to be applied mechanically. Public bodies should use their judgment in applying the Principles to produce reasonable, fair and proportionate results in the circumstances. The Ombudsman will adopt a similar approach in deciding whether maladministration or service failure has occurred.

Appendix B

Selected Case Summaries

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

Assembly Ombudsman for Northern Ireland – Selected Investigation Summaries

Department of Justice – Northern Ireland Courts and Tribunals Service

Reasonable Adjustments in Court Room

In this case, Mrs Brenda Hale MLA sponsored a complaint about the actions of the Northern Ireland Courts & Tribunals Service (NICTS). It was the complainant's contention that NICTS had failed to provide reasonable adjustments to accommodate her severe/profound hearing loss during court proceedings held at Newry Courthouse from June 2012 to February 2013. She also complained about NICTS's subsequent handling of her complaint.

My investigation revealed that the responsibility for organising an interpreter for the complainant's first court appearance lay with the Public Prosecution Service and thereafter with the presiding District Judge at Newry Magistrates Court.

I have no jurisdiction in relation to the actions of someone who holds a judicial office, including a District Judge, but rather my authority extends only to the administrative actions of NICTS administration staff taken other than on instruction or implied instruction of a member of the judiciary. As such, my investigation of this complaint focused on NICTS's administrative handling of her complaint. In this regard, I considered that NICTS gave a comprehensive response to the complainant in its letter dated 7 January 2014, in which it outlined the responsibilities of the District Judge, NICTS and the action taken during the hearing on 1 February 2013. Overall, I was satisfied that NICTS took the complaint seriously and outlined that provision had been made for her disability. Consequently, in the absence of any identified evidence of maladministration on the part of NICTS, I could not take any further action on this complaint.

Department of Finance & Personnel – Land & Property Services

Rating of Empty Property

In this case, Mr Dominic Bradley MLA sponsored a complaint about the actions of the Department of Finance & Personnel – Land & Property Services (LPS). The complaint concerned LPS's handling of his rate account for an empty property he owned. He stated that as a result of LPS's failure to issue rate bills for his empty property in a timely manner, he incurred arrears, backdated to 1 October 2011. He explained that if LPS had informed him that rates were due on the property, he would have rented it out. He therefore believed that LPS should write-off the arrears due from October 2011 to July 2013.

From my investigation of this case, it was clear to me that there was maladministration in LPS's handling of this rate account, which resulted in the complainant not receiving a rate bill automatically when the Rating of Empty Homes legislation came into effect in October 2011. However, I noted that LPS had acknowledged and apologised to the complainant for its handling of his rate account and, in an effort to address this matter, considered his case under its Shortfall in Service Guidelines. These Guidelines were developed by LPS, having regard to previous complaints which I

had investigated about LPS concerning handling of rating matters. In this case, LPS approved a 25% reduction in his rate liability for the period October 2011 to March 2013, amounting to some £389. I also noted that following the inspection of the complainant's property in December 2013, the revaluation assessment led to a £100 reduction in the annual rates for the 2013-14 rating year.

Overall, in light of LPS's action in reducing the assessed capital value of the property, in reducing the level of rate arrears and in allowing 21 months to clear the remaining rate balance, I did not consider that I could achieve a better outcome for him than LPS had already offered. As such, I decided to take no further action on this complaint.

Department of Agriculture & Rural Development

Neighbouring Farm Dispute

Alderman Gregory Campbell MLA sponsored this complaint regarding the actions of the Department of Agriculture & Rural Development (DARD), in its handling of a complaint about the farming practices being employed by his neighbour, whose cows were allegedly interfering with his property and eating his shrubs and flowers.

My investigation revealed that, according to DARD, the effect that the neighbour's cows were having on the complainant's property was a private matter for him to resolve with his neighbour. As such, in the absence of any identified evidence of maladministration on the part of DARD in administering its Cross-Compliance rules, I could not take any further action on this complaint. I did, however, suggest that the complainant may wish to seek legal advice if he considered that his property was being damaged by his neighbour's cattle.

Single Farm Payment Eligibility

This complaint, sponsored by Adrian McQuillan MLA, concerned the Department of Agriculture and Rural Development's (DARD's) decision that one of the complainant's fields was ineligible for Single Farm Payment (SFP) as it was deemed unfit for grazing. The complainant sought a review of DARD's inspection findings in relation to an on-farm inspection carried out in October 2010. He complained that during the two stages of DARD's Review of Decisions Procedure, the Appeal Officers had difficulty in obtaining information from DARD's Regional Inspector.

The complainant took issue with DARD's contention that there was no evidence to prove that the photographs he had provided of cattle grazing in a field related to the field in question. He also complained that following the DARD decision to set aside an External Panel's recommendation DARD summoned the Head of Countryside Management Unit, the Regional Inspector and an External Panel legal officer to a further meeting to discuss how the Department might defend a potential judicial review.

I arranged for enquiries to be made of the DARD Permanent Secretary who provided me with additional documentation. Having examined the relevant correspondence, I was satisfied that there was no evidence to suggest that the Appeal Officers had had difficulty in obtaining information from the Regional Inspector.

In relation to the photographs, I noted that they were not dated or clearly labelled. I determined therefore that DARD's contention regarding the photographs was reasonable. I also accepted DARD's explanation that they were not calling into question the complainant's integrity and I was satisfied that there was no evidence to show that a meeting took place between the Head of Countryside Management Unit, the Regional Inspector and an External Panel legal officer. I found no evidence of maladministration in this instance and therefore I did not uphold the complaint.

Application of Sickness Absence Policy

This complaint, sponsored by Mervyn Storey MLA, stated that the Department of Agriculture and Rural Development (DARD) decision to issue the complainant with a written absence warning in July 2013 was

unfair as his recent absences had been related to an accident at work and ongoing medical problems. The complainant stated that the written warning was issued solely on the basis of number of days absent and no consideration had been given to the nature of his illness or its cause. Thus he claimed that DARD was failing to apply the policies of the Northern Ireland Civil Service (NICS) Inefficiency Sickness Absence policy.

I arranged for enquiries to be made of the DARD Permanent Secretary who informed me that the complainant had been issued with a written warning following a sickness absence level of thirty four working days. The NICS Inefficiency Sickness Absence policy states that absence will be reviewed after 4 occasions or 10 working days in a rolling 12 month period. An absence lasting 20 consecutive working days or more is classed as long term sickness. The complainant's absence pattern had been such that his sickness level reached both trigger points for the consideration of Inefficiency Action.

I found that all of the steps outlined in the NICS policy were followed in the complainant's case. Furthermore, there was clear evidence that DARD had followed NICS policy in terms of considering the required range of factors and the rationale for the decision to issue a written warning was clearly recorded. Having carefully considered the matters raised by the complainant, I was satisfied that DARD did consider the factors presented by the complainant including the nature and cause of his illness. I found no evidence of maladministration in the decision making process to issue a written warning. Such a decision is discretionary and I do not have the power to set aside decisions reached in the course of an appeal process or to revisit issues on which these decisions are based, unless the decision is attended by maladministration. I found no evidence of maladministration in this instance and therefore I did not uphold the complaint.

Department of Agriculture & Rural Development - Rivers Agency

Alleged failure to follow procedures

In this case, sponsored by Michael Copeland MLA, the complainants informed me that they had been experiencing flooding to the front and rear of their home since the commencement of housing development work on a site directly adjacent to their property. They alleged that the flooding was directly related to work which was carried out by the site developers on a stream running behind their home; namely the extension of a culvert and piping of a storm drain into that culvert. The complainants claimed that the Rivers Agency did not follow the correct procedure in providing the required statutory consent for the work nor did it have a system in place to monitor the watercourse before, during or after the work on the culvert.

My investigation of the complaint focused on the following 2 alleged failures by Rivers Agency:

- Monitoring of the watercourse before, during and after the work on the culvert; and
- Adherence to the correct procedure in providing consent to undertake works on a watercourse.

In the course of the investigation, I established that, despite having no legal duty to inspect watercourses, Rivers Agency had nonetheless carried out regular inspections of the stream in question and had completed appropriate maintenance works as necessary.

As Ombudsman I am not authorised or required to question a discretionary decision taken by a public body, unless I find evidence of maladministration in the making of the decision. My investigation of the second alleged failure did not therefore consider Rivers Agency's decision to grant consent; rather my examination focused on the administrative process followed by the Agency in reaching its decision.

My investigation found that although the complainants appeared to suggest that Rivers Agency had granted approval for the works retrospectively, this was not entirely reflective of events. I confirmed that agreement in principle had in fact been given to the developer ahead of work commencing. Whilst full consent was indeed granted retrospectively, I was satisfied that, under the legislation which governs the process of granting such consent, the Agency has the power to so act.

Accordingly, having found no evidence of maladministration in relation to either of the allegations I investigated, I did not uphold the complaint.

Northern Ireland Commissioner for Complaints – Selected Investigation Summaries

Northern Ireland Legal Services Commission

Alleged failures in the Legal Aid System

I received a complaint about the Northern Ireland Legal Services Commission (the Commission) in which the complainant stated that maladministration and systems failure in the legal aid system led to the abuse of public funds and that this had a serious adverse impact on his life over a period of years.

In a letter of complaint to me the complainant stated that during his divorce and ancillary proceedings between his ex-wife and himself there was a failure to control legal aid funding, and disproportionate costs. This encompassed lack of regulatory controls or monitoring of activity in the following matters; in changing legal representation; the introduction of new allegations; and escalating costs; that there was no requirement for mediation; that there was no system to take into account malicious or vexatious activities; that governance failures in the legal aid system led to disproportionate costs and that there was a lack of scrutiny of these costs; and no monitoring of assets to recover costs.

From my careful and detailed examination of the information available to me I did not find maladministration in the Commission's handling of the complainant's opponent's legal aid funding. The Commission's remit regarding the administration of legal aid is limited, and the Commission does not have authority or governance responsibilities over many of the areas with which the complainant was dissatisfied. Whilst I accepted that this process was difficult for the complainant, I found that the Commission fulfilled their limited responsibilities regarding legal aid appropriately. I found that it is clear that the Commission have regulatory controls and procedures in place in the areas of complaint, and the Commission followed these in the complainant's opponent's case. I also found that in the matter of disproportionate costs, the Commission exercised their governance responsibilities appropriately; in determining the applications for Legal Aid met the means and merits tests; ensuring that the taxed bills were correct; and scrutinising costs regarding expert evidence where they had statutory authority to do so.

I found that the Commission acted in accordance with their procedures in this case, and I found that they are not required by legislation to monitor assets for the purpose of recovering monies. It was clear, to me however, that there is a gap in the legislation which permits claimants to avoid or delay informing the Commission of the outcome of their case and thereby delay the application of the statutory charge, which enables the Commission to recoup monies spent. The Commission have made efforts to address this gap in the legislation, and have identified deficiencies in their case management system, and areas for review in the legislation regarding timely notifications of case outcomes.

I welcome the acknowledgement from the Commission and the Department of

Justice (DOJ) that reform of the legal aid system is needed. Whilst any reforms which improve the governance arrangements for control of legal aid funds will not benefit the complainant, I note that in his complaint to me, the complainant expressed the wish that the deficiencies, as he saw them, in the legal aid process would not occur again to anyone else. I too consider that further action to address the deficiencies is required, I would urge the DOJ and the Commission to expedite the reform programme and to this end I have drawn the conclusions of this report to the attention of the DOJ Permanent Secretary.

Northern Ireland Fire and Rescue Service

Alleged mishandling of selection procedure

The complainant in this case had failed to be shortlisted for the post of Wholetime/ Retained Firefighter. The Northern Ireland Fire and Rescue Service (NIFRS) explained to the complainant that he was not shortlisted because "at the closing date for applications" he had failed to demonstrate how he was "currently" able to meet the shortlisting criteria. The complainant said that this requirement was not explained to applicants nor is it fair. The complainant had indicated on his application form that he had other employment from which he would resign if successful in his application. However, the NIFRS expect applicants to resign from other employment before a definite offer of employment is made, which the complainant considers to be unreasonable.

As a result of my investigation, I concluded that the complainant had suffered injustice as a result of maladministration by the NIFRS with regard to following:

- a lack of clarity in the application documentation;
- failure to advise applicants that the shortlisting criteria must be met at closing date for applications;
- failure to shortlist the complainant.

I found that the complainant experienced the injustice of disappointment, distress, frustration and of the denial of an opportunity to participate in the NIFRS competition entered in good faith. In recognition of the maladministration and resultant injustice, I recommended that:

- the Chief Executive of the NIFRS provide the complainant with a full written apology for its failures;
- the NIFRS review its application documentation for all future competitions to ensure compliance with good selection practice;
- the NIFRS issue guidance regarding the shortlisting methodology to those eligible to participate as panel members in recruitment competitions.

I am pleased to record the recommendations were accepted in full by the NIFRS.

Belfast Health and Social Care Trust

Harassment and Bullying

The complainant in this case, an employee of the Belfast Health & Social Trust (the Trust) raised a number of issues related to alleged harassment and bullying that she experienced while training and working as a Specialist Registrar in the School of Dentistry at the Royal Victoria Hospital. I identified nineteen separate issues including the Trust's handling of the complainant's allegation of harassment and bullying behaviour by a former Head of the Paediatric Dental Unit and the actions of the Trust both during and after its investigation of her complaint.

I found maladministration by the Trust which was characterised by its failure, after its decision to investigate the complaint of harassment and bullying, to provide the complainant with relevant and essential information and failure to take all appropriate action. I found those failures to have been compounded by the actions (including inaction) of senior staff in dealing with such serious matters.

I also found that, as a consequence of those failures, reports that the complainant made over a period exceeding one year to the Trust's senior managers about the inappropriate behaviour of the Head of the Paediatric Dental department were not acted upon in any meaningful way.

During the extended time in which the Trust investigation was conducted, I found that the Trust breached its own procedures by failing to provide the complainant with appropriate information, including information about the support services she could access in the form of the Occupational Health Service and the Confidential Counselling and Advice Service.

My investigation established that the complainant clearly believed she had been subjected to undermining and hostile behaviour from colleagues, as a direct consequence of having made her complaint to the Trust. However, when the complainant reported this, the Trust failed to take any action to determine whether her perceptions had any basis and, if they had, to proactively address the hostility she was experiencing.

Also. by discussing the investigation inappropriately, the Head of the Paediatric Dental department breached confidentiality, which resulted in his exclusion from the Paediatric Dental department. However, the Trust failed to consider the fact that the confidentiality breach represented 'gross misconduct' and it also failed to consider whether disciplinary proceedings should have been initiated for such misconduct.

As a result of its investigation the Trust recommended, among other things, that the Head of the Paediatric Dental department should be subject to disciplinary proceedings. However, the Trust did not schedule the disciplinary hearing until 4 months after the completion of its investigation. Also, the Trust failed to provide the complainant with information about the disciplinary proceedings or to inform her, in a timely way, of the confirmed date of those proceedings. The Trust also failed to inform the complainant, directly and in person at the earliest opportunity after receipt, of the resignation of the Head of the Paediatric Dental department from the Trust, nor did it advise her of its decision to cancel the disciplinary hearing that had been recommended.

Although the Trust provided the complainant with an unqualified assurance that her training would not be compromised as a result of her submitting a complaint, the complainant's training was adversely affected to the point that she received very little training during a 7 month period. Also, the Trust failed to provide the complainant with information concerning the steps it was taking to facilitate the continuation and completion of her training. In addition, there were avoidable delays by the Trust in making alternative arrangements for the continuation of her professional training and it failed to ensure that those delays were kept to a minimum.

Finally, the Trust failed, in breach of its own policy, to implement recommendations made as a result of its investigation of the complaint while at the same time failing to inform the complainant of the steps it was taking to prevent a recurrence of her experience.

I made a number of recommendations in relation to actions that the Trust should undertake to address all the weaknesses identified in this regrettable case, so as to avoid any recurrence. Those recommendations included an urgent review of the implications of this case for the wider Trust and consideration of whether the learning developed from that review should be disseminated across the wider HSC. I also recommended that the complainant should receive a written apology from the Chief Executive (CE) of the Trust. I am pleased to record that the CE accepted all my recommendations.

Loss of Employment Opportunity

This complainant complained to me, in April 2011, about the actions of the Belfast Health & Social Care Trust (the Trust) in its ongoing handling, at that time, of the recruitment of a post of Locum Consultant in Paediatric Dentistry and the applications she made for that post. The complainant had made a separate complaint to me about the actions of the Trust in relation

to a complaint of harassment and bullying she experienced while training and working in the School of Dentistry.

My investigation found that, due to its urgent need to recruit a Locum Consultant Paediatric Dentist without delay, the Trust used parallel procedures involving the advertisement of the post through its own direct recruitment procedures and attempts to source a suitable candidate by means of private recruitment agencies which were contracted by the Trust.

The complainant made her initial application for the post in April 2011 to a recruitment agency and she subsequently made applications to two other recruitment agencies that the Trust had also contracted with. My investigation established:-

- a number of instances of maladministration by the Trust in its handling of the processes involved including failures to act on, or take appropriate action in response to, those applications;
- as a consequence of that maladministration, the complainant had not, by mid June 2011, received an indication of the outcome of these processes in response to her applications for employment, despite her being the only person who had expressed an interest in filling the post and despite the Trust contacting approximately twelve recruitment agencies about this vacancy;
- although the Trust offered the post to the complainant, on 15 June 2011, it still had not identified a start date and it suggested, due to its need to schedule patients clinics, that the proposed starting date should be 29 June 2011;
- in addition to making applications to a number of the recruitment agencies the complainant had also made a direct application for the post to the Trust itself in April 2011 when the post had been advertised by the Trust. However, while the Trust received only two applications and shortlisted only the complainant , she was not contacted by the Trust in relation to her application for a period of 20 weeks; and
- the 20 week period taken by the Trust to set up a selection panel and to shortlist the two applications received was excessive to the extent that the delay itself constituted serious maladministration.

In these circumstances, I concluded that the complainant had sustained the loss of opportunity of employment in 2011 in the School of Dentistry and that she was fully justified in bringing her complaint about the Trust to my Office. I recommended that the complainant should receive a written apology from the Chief Executive (CE) of the Trust. I am pleased to record that the CE accepted my recommendation.

Ballymoney Borough Council

Recruitment Practice

The complainant in this case complained about the actions of Ballymoney Borough Council. In particular, he complained that he was denied a full time post after being placed first on a reserve list and accepting a part time post whilst waiting on a permanent full time post. He also complained that there was undue delay in responding to his MLA's enquiries.

I arranged for enquiries to be made of the Council and in his response, the Chief Executive advised that both aspects of his complaint were well founded. In light of this, the Chief Executive proposed a settlement of a permanent full time post and the calculation of any financial loss suffered by the complainant as result of the failure to offer him a post in September 2013, including any additional salary and pension contribution. The Head of Human Resources also reviewed the Council's policy and practice in relation to the operation of the reserve list. Changes will be proposed to ensure for the future where part time and full posts are advertised in one recruitment exercise, candidates are fully informed about the operation of the reserve list in relation to subsequent vacancies to avoid a recurrence of this complaint.

The Commissioner for Complaints (NI) Order 1996 provides that I may seek a settlement if this seems to be desirable to me. In this case I regarded the proposal outlined above to be a satisfactory remedy for the Council's failings in this case and thereby exercised my discretion under Article 12(1) of the above Order to accept this settlement and discontinue my investigation. I was later informed by the Council that the complainant began his full time post in October 2014 and the financial loss was also remedied.

Larne Borough Council

No Evidence of Maladministration

The complainant in this case was aggrieved about what he regarded as an "abuse of power" by the Chief Executive of Larne Borough Council in relation to two matters, i.e. delay in issuing lease documents and the need for him to resign as a director of a community based association. The complainant was also aggrieved about the Council's handling of a complaint he made to it in February 2012. In this regard, the complainant considered that the Council had failed to apply its internal complaints procedure in dealing with his complaint.

Having completed a detailed investigation of this complaint, I found no evidence of maladministration on the part of the Council, either in relation to its handling of the issue of lease documents in this case or in advice it provided in relation to good governance, accountability, good practice and transparency which led to the complainant resigning from the positions he held in two community based associations. In these circumstances, I was unable to uphold the various aspects of these issues raised in the complaint. Similarly, I found no evidence of maladministration by the Council in its complaint handling and I was also unable to uphold this aspect of the complaint.

Northern Ireland Commissioner for Complaints – Health and Social Care - Selected Investigation Summaries

Belfast Health and Social Care Trust

Treatment of son at the Royal Belfast Hospital for Sick Children

This complaint concerned the actions of Belfast Health and Social Care Trust (the Trust) following the attendance of the complainant's young son at the Royal Belfast Hospital for Sick Children's (RBHSC) Casualty Department in September 2009. The child's parents were concerned about a swelling to his arm. X-rays and blood samples were taken and they were advised to attend the next day to see an orthopaedic consultant. On arrival at the hospital the parents were met by the PSNI and social workers who indicated to them that a number of unexplained fractures had been identified on the child's arm and shoulders.

The complainant had severe reservations about the composition, conduct and comments made during the initial Child Protection Case Conference (ICPCC) which took place in September 2009. Additionally, he was concerned that despite the fact it was recognised at the IPCC that further expert medical opinion was vital to the progression of the case, the Trust took no action to expedite securing this advice. When fresh medical opinion was eventually obtained it suggested the possibility that the injuries to the child may have occurred accidentally. In November 2010, the names of child and his brother were removed from the Child Protection Register.

I did not find maladministration in; the medical aspects of the complaint; the comments, composition or decisions of the ICPCC; the child leaving hospital following his attendance at A&E; comments alleged to have been made by social workers; or complaints handling.

However, I found maladministration in relation to; the taking of forensic photographs of the child; the supervisory arrangements regarding the maternal Grandparents; the vetting of supervisors as part of the Child Protection Plan; the supervision of the child's sleeping arrangements; the social services visiting arrangements as part of the Child Protection Plan; delay in obtaining necessary further medical advice to progress the case; failings in a number of administrative actions by social services; providing incorrect advice; and cancellation of meetings

Whilst I was content that social services acted correctly in carrying out an investigation, I was satisfied that the failings identified by my investigation had damaged and undermined trust and created ill will between the complainant and health and social care staff. I was struck by a lack of focus and the absence of clear planning regarding the handling and progression of the case, a significant failure of management and the absence of proactive intervention.

I recommended that the complainant receive a written apology from the Chief Executive of the Trust and that he remind his senior management and professional staff of the importance of clarity and focus regarding the application and monitoring of policies and procedures. I highlighted the importance of accurate and comprehensive record keeping by all staff, particularly those involved in child protection procedures. In addition I retained the services of my Independent Social Work advisor to work on an action plan with the Trust to ensure that lessons have been learned by all professionals involved from this complex and distressing case.

Care and treatment of Late Husband at the Royal Victoria Hospital, Belfast

The complainant in this case was dissatisfied with the care and treatment provided to her late husband by the Royal Victoria Hospital (RVH), part of the Belfast Health & Social Care Trust (the Trust). Following an MRI scan in April 2011, the complainant's husband was diagnosed with a brain tumour and was immediately referred that day to the Neurosurgery Department of the RVH, the Regional provider of Neurosurgery Services. Unfortunately, the condition of the complainant's husband deteriorated and he died on 1 July 2011.

The complainant was unhappy about delays in her late husband's treatment; the failure of the Neuro-Oncology Multi-Disciplinary Team (the MDT), which meets weekly, to discuss her husband's case in a timely way; and the lack of direct support and personal contact they received from the RVH Neurosurgery team. Although the complainant had written to the RVH on two occasions expressing her concerns about the care and treatment afforded to her husband, she considered that the Trust had failed to address those concerns.

I considered the hospital and GP medical records relating to the complainant's husband and the complaints documentation provided to me by the Trust. I also obtained Independent Professional Advice (IPA) from a Consultant Neurosurgeon.

My investigation found a number of incidences of maladministration by the Trust. In particular I found that:

- the Trust failed to ensure that the Locum Consultant Neurosurgeon in charge of the complainant's husband, was fully informed, as soon as possible after his appointment, of the policies and procedures of the MDT and about the Trust's management of urgent and deteriorating patients;
- as a consequence, there was avoidable delay in the decision being made that a biopsy should be performed in order to obtain an urgent histological diagnosis of his tumour;
- there was avoidable delay by the RVH Neurosurgery Department in scheduling the biopsy, which it has been unable to explain. Although standard Trust practice is to operate on patients with an intrinsic malignant brain tumour within two-weeks, the biopsy in this case was initially scheduled to be performed 7 weeks after the date of diagnosis. Although the biopsy was rescheduled in light of the patient's deteriorating

condition, this only reduced his waiting time by 8 days thereby compounding the maladministration;

- despite indications in May 2011 by RVH Neurosurgery Department of the need for biopsy to be brought forward again, I found no evidence of any follow up action having been taken by the RVH in an attempt to determine whether this was possible;

- there was complete reliance on the MDT for making decisions about the patient's care. His case was discussed by the MDT on 6 May 2011. However, the Trust failed, without reasonable explanation, to include his case for discussion of his deteriorating condition at the MDT meeting on 13 May 2011. When the case was discussed by the MDT on 20 May 2011 that discussion still failed to influence the care management plan.

- the Neurosurgery Department failed to have any direct and personal contact with the patient and his family. In this regard, the Neurosurgical Department failed, following the decisions of the MDT on 6 and 20 May 2011, to make an urgent appointment for the patient to attend the neurosurgery outpatient clinic in order that he would have the opportunity for a consultation with the neurosurgeon responsible for his care;

- as a consequence of those failures, the patient was denied the opportunity by the Trust to meet with his neurosurgeon to discuss his treatment options; neither was he made aware of the key role of the Nurse Specialist who was available to address any concerns he or his family may have had regarding the biopsy, obtaining test results, possible further treatments and their appropriateness.

I regarded these significant failures by the Trust as a cause of deep concern. I was in no doubt that the inadequate level of care and treatment afforded to the complainant's husband contributed largely to the distress and despair that he experienced. This led, within little more than a calendar month from his initial diagnosis, to an attempt to end his own life. I noted regretfully that the complainant and her daughter experienced the injustice of distress, upset, anxiety, frustration, uncertainty and feelings of helplessness as a consequence of maladministration by the Trust.

The Trust acknowledged that there were aspects of this case that could have been better managed. I was reassured that the Trust had already initiated a number of service improvements to address the various shortcomings that occurred in this case, with the aim of similar events being avoided in the future. However, I made a number of recommendations in order to help improve services for neuro-surgery patients and their families in the future. In particular, I recommended that the Trust should undertake as a matter of urgency a systemic review of the Neuro-Oncology Department of the RVH in relation to the referral arrangements. I am pleased to record that the Trust has accepted my recommendations.

I also recommended that the Chief Executive (CE) of the Trust and the Consultant Neurosurgeon involved in the case should provide the complainant with a comprehensive apology for the instances of maladministration I had identified. I was pleased to record that the CE and the Consultant concerned also accepted this recommendation.

Care and Treatment – Belfast City Hospital

I received a complaint about the care and treatment provided to the complainant's late wife, by the Belfast Health and Social Care Trust (the Trust). The complainant raised concerns about the delay in the diagnosis of his wife's cancer and he remained unhappy about the responses he had received from the Trust to his complaint.

Despite a number of tests and subsequent outpatient appointments from December 2008 until October 2009 the cause of the bleeding experienced by the patient in this case was not found. In September 2009 the patient was admitted to Belfast City Hospital (BCH) with nausea and shortness of breath and underwent various tests. The Trust stated that the results of these tests were normal and discharged the patient on the basis that her long-standing complaint of nausea could be

investigated further as an outpatient. An outpatient appointment took place on 21 October 2009. Due to her persistent vomiting and weight loss, the patient was re-admitted to Belfast City Hospital at her outpatient appointment and a CT scan on the patient showed a duodenal-jejunal (small intestine) mass and an examination of the oesophagus, stomach and duodenum disclosed a malignant tumour.

Further tests revealed an abnormality on the patient's liver and she was transferred to the Mater Hospital, (the relevant Regional Centre), on 3 December 2009, a laparotomy was performed and while her initial post-operative progress was satisfactory a subsequent CT scan revealed further problems which required surgical intervention.

Unfortunately the patient's condition deteriorated; it was decided that she was too unwell for further surgery and sadly she passed away on 22 December 2009.

Having obtained Independent Professional Advice (IPA), I have concluded that overall the clinical care provided to the patient was unsatisfactory. I found that the patient's tumour could have been diagnosed in February 2009, some eight months before the Trust provided a diagnosis. My investigation also revealed that a capsule endoscopy procedure could also have potentially provided a diagnosis eight months earlier, had the referral request, been carried out at the Royal Victoria Hospital (RVH). I found that the Trust missed a further opportunity to diagnose the patient's tumour in October 2009. I, therefore, made a finding of maladministration in relation to the Trust missing a number of opportunities to accurately diagnose the patient's condition and its further failure to meaningfully respond to the complainant's complaint about his wife's treatment. I also determined other failings and I recommended that the Trust conduct a detailed review of each instance of maladministration identified by this investigation and that it disseminate the learning developed from each review. I also recommended that an apology in writing should be issued to the complainant for the poor quality of the care of his late wife. I further recommended that that the Trust conduct an urgent review of its *'Inter-hospital transfer of patients'* policy. I made a number of other detailed recommendations and I am pleased to state these have been accepted in full by the Trust.

Care received from the Orthopaedic Services Fracture Clinic based at Antrim Area Hospital

Antrim Area Hospital (AAH) hosts the Orthopaedic Services Fracture Clinic which is provided by the Belfast Health and Social Care Trust (BHSCT). In this case I received a complaint about the care and treatment the complainant received from this clinic following a foot injury he sustained.

In particular the complainant alleged that the clinic failed to recognise that he needed surgery for a fracture of his fifth metatarsal; that it did not recommend physiotherapy when treating his fracture; that it failed to provide him with appropriate treatment which consequently extended his period of recovery. Further he complained that the hospital did not provide adequate orthopaedic care to him.

My investigation, which had regard to the clinical advice I obtained from my Independent Professional Adviser (IPA), found no evidence of maladministration by the BHSCT in relation to the matters complained of. I therefore did not uphold this complaint.

Northern Health & Social Care Trust

Failure in clinical care

The complainant's elderly father was chronically ill, being in end-stage dementia and having a history of falls, chest infections, pressure ulcers and urinary tract infections. He resided in a nursing home but had spent some time in hospital for the treatment of aspiration pneumonia. Prior to his discharge back into the nursing home, a Tissue Viability Nurse (TVN) had treated pressure ulcers which had developed on his foot and hip. The TVN made recommendations for the continued treatment and care of these ulcers in the nursing home. The patient was readmitted to hospital several months later where it was noted that

there had been some deterioration in the hip ulcer since the patient's previous stay in hospital. The patient remained in hospital until his death, two months later.

The complainant contacted me specifically to query a report produced by the Trust which concluded that care of the ulcers had been "appropriate".

I noted that the nursing home was contracted to provide care services for the Trust and, as such, had acted on behalf of the Trust in respect of the care it provided to the patient. My investigation found that while the nursing home had initially followed the TVN's recommendations, an alternative treatment was later introduced and there were no written records available which provided the rationale for this change. My clinical advisor's advice satisfied me that the alternative treatment was appropriate; however I was nonetheless critical of the absence of a proper written record.

My investigation also established that the nursing home did not consult a TVN when it became apparent that the patient's hip ulcer had deteriorated despite the treatment that was being given. My clinical advisor confirmed that the lack of referral to the TVN was a failing and I concluded that this failure constituted maladministration. However, taking account of clinical advice, I was satisfied that, given the patient's chronic condition, other treatment options would not have definitely healed the patient's hip wound.

I recommended that the Chief Executive of the Trust should write a letter of apology to the complainant and this recommendation was accepted.

Care and treatment received from Antrim Area Hospital

This complaint concerned the care and treatment of the complainant's husband during two hospital admissions to Antrim Area Hospital (AAH) in 2012 and 2013. My investigation, which had regard to the clinical advice I obtained from my Independent Professional Advisor, found instances of maladministration on the part of the NHSCT in relation to the following matters –

- Failure to formulate a treatment plan in the form of a nursing care plan
- Failure to administer a clexane injection
- Failure to change a morphine patch on the correct day
- Failure to note medication errors and complete incident forms
- Failure to have regard to the patient's dignity and respect by discharging him with food on his face and clothes
- Failure to record the condition of the patient's head wound on day of discharge
- Failure to complete a record after an incident occurred with the patient's bed
- In respect of complaint handling - failure to respond to the complaint in a timely manner.

I also found that there was a failure by the Trust to respond to the complaint in a timely manner

In the course of the HSC complaints process the NHSCT apologised to the complainant for the failures in care and treatment in this case and also for their complaints handling. I considered that the failings in regard to record keeping caused the complainant the injustice of frustration and uncertainty. I recommended that the NHSCT's Chief Executive provide a written apology to the complainant. I also recommended that the Trust ensure that staff are made aware of their obligations in relation to record keeping. I am pleased to record that the Chief Executive accepted my findings and recommendations.

Southern Health & Social Care Trust

Failure in clinical care

This complaint concerned the care and treatment provided to the complainant's elderly mother, who was admitted to Loane House, a two ward assessment, diagnosis and rehabilitation unit. During her in-patient stay she had two falls that were not witnessed. She was transferred to Craigavon

Area Hospital after the second fall, but in September 2012 she sadly passed away.

I made findings of maladministration in relation to; the Trust failure to carry out observations in a timely manner; delay in providing the reports of a CT scan; failure to provide pain relief in a timely manner; and the provision of inaccurate information during the complaints process. I recommended that the Chief Executive of the Trust make an apology to the complainant for the injustice suffered. I am pleased to record that this was accepted.

I did not find maladministration in other aspects of the complaint. With regard to the circumstances surrounding the falls experienced by the complainant's mother, I concluded that these were unfortunate accidents, and the poor physical condition of the patient and the presence of confusion and disorientation were major factors in their occurrence. I found that reasonable precautions were taken to minimise the risk of falling.

Care and treatment received from Craigavon Area Hospital

This complaint concerned the care and treatment provided to the complainant's wife following her admission, due to severe abdominal pain, to Craigavon Area Hospital (CAH) and subsequent death whilst an in-patient.

While in CAH she had various diagnostic procedures carried out. Unfortunately she developed a severe respiratory infection and was transferred to the intensive care unit (ICU) after suffering respiratory failure. Following intubation and further treatment to remove fluid from her lungs over the subsequent days, the complainant's wife was transferred back to a surgical ward. Her condition again deteriorated and rather than be readmitted to ICU, she continued to be treated on the surgical ward up until her death.

I identified maladministration in relation to the following issues. There was a failure in communication in that the seriousness of his wife's condition was not explained to the complainant or his family at the point that the complainant's wife was being transferred from ICU back to the ward. Additionally, there was a failure to alert the family to deterioration of the patient's condition on the evening prior to her death. I also found failures in the timing of the observations of the complainant's wife's and in the completion of documentation. I did not uphold a number of other aspects of the complaint.

I recommended that the Chief Executive of the Trust issue an apology to the complainant for the maladministration I identified. I am pleased to report that the Chief Executive accepted my recommendation.

Failures in clinical care at Craigavon Area Hospital

The patient in this case had a lesion on her finger and was referred by her GP to the Trust's Dermatology Department at Craigavon Area Hospital. Her first appointment occurred in March 2011, 10 months after the referral. A Specialty Doctor in Dermatology diagnosed a benign cyst and, on attempting to treat it with a steroid injection, the patient fainted. The patient was advised to return for the treatment after the birth of her baby. However, in August 2011, the patient returned to the Dermatology Department before her baby was born, being concerned that the lesion had increased significantly in size.

The complainant was reviewed by the same doctor, who sought advice from the Consultant Dermatologist. The consultant examined the lesion and, in common with the doctor's previous diagnosis, also took the view that the lesion was a benign cyst. The consultant directed that the patient should be referred to a plastic surgeon for excision of the lesion.

The patient was planning to emigrate and was still awaiting an appointment with a plastic surgeon at the point of emigration. At this time she enquired and was informed by the Trust that her case had been assessed as non-urgent.

Subsequent to her arrival in her new home, the lesion was biopsied and diagnosed as a malignant spindle cell melanoma and her finger was amputated in September 2012. However, by that stage, secondary spread

of the cancer had occurred and the longer term prognosis for the patient was poor.

The patient complained about the previous care she had received from the Trust. The Trust expressed regret at how matters had developed and acknowledged that the case should have been referred to a plastic surgeon sooner. The patient then asked me to consider her complaint.

I sought advice from an independent Consultant Dermatologist and, as a result, I found maladministration in the following respects

- Excessive delay in obtaining a routine appointment at the Trust's Dermatology Department.

- Failure by both doctors to consider other diagnoses (including malignancy) in light of the atypical nature of the lesion and to arrange a biopsy of the lesion.

In view of the distressing impact that these failures had upon the patient's health, I was satisfied that the patient sustained an injustice as a result of maladministration identified by my investigation. I recommended that the Chief Executive of the Trust should write a comprehensive letter of apology to the patient, acknowledging the failures of the clinicians involved in the patient's care and the effect that those failures had upon the patient's health. I specified that the letter should also detail the changes that have been implemented within the Dermatology Department as a result of the learning which has been drawn from this case.

South Eastern Health & Social Care Trust

Failure in clinical care

The complainant's husband, who had a history of liver cirrhosis and suffered from chronic kidney disease, was admitted to hospital due to worsening symptoms. He passed away three weeks later. The complainant was concerned that there had been delay in her husband's transfer to a specialist gastrointestinal ward and that this had a detrimental impact on the outcome. She also felt that she should have been informed about the seriousness of her husband's condition more promptly than occurred. I understood this to be a reference to the fact that her husband was so ill that he succumbed to the disease within 16 days of being admitted to hospital.

I agreed to consider this complaint once it became clear that the HSC complaints process had failed to resolve matters to the complainant's satisfaction.

In terms of communication of the seriousness of the patient's condition, there was evidence that the Trust did not inform the complainant of the potentially very severe prognosis until 8 days after her husband was admitted to hospital. However I was satisfied that, even at that point, clinicians could not be definitive as the outcome was not certain. After careful consideration I accepted that the Trust could not have informed the complainant of the likely outcome any sooner than it did.

My investigation found that although the patient spent longer in a Medical Assessment Unit (MAU) prior to transferring to the specialist gastrointestinal ward, he nonetheless received the same treatment. In particular, the required treatment for bacterial peritonitis was commenced while the patient was still in MAU. I found no evidence that the patient experienced any detriment as a result of his extended stay in the MAU. However, I was dissatisfied that a review of the patient by a gastroenterologist was delayed by 6 days, a period which I considered to be unreasonable having reflected on the advice of my independent clinical advisor. This constituted maladministration and I was satisfied the complainant experienced an injustice in terms of the unnecessary anxiety created by the prolonged wait. I recommended that the Chief Executive of the Trust should write a letter of apology to the complainant by way of remedy.

Health Service Provider – GP

Removal from Practice List

This case concerned an allegation that the complainant was removed from her GP Practice patient list with no prior

warning. The Health and Personal Social Services (General Medical Services Contracts) Regulations (Northern Ireland) 2004 (the Regulations) are quite explicit as to the procedure to be followed and the actions to be taken to remove a patient from a Practice list. Save for exceptional circumstances specified in the Regulations, removal of a patient from a Practice list requires that, within 12 months prior to the removal, the patient should be given a warning that he/she is at risk of removal and an explanation of the reasons for such action; this gives the patient an opportunity to remedy the situation and improve their behaviour before they are removed from the Practice list.

My investigation revealed that the complainant was not given a warning nor was there any record of how the complainant's circumstances met the relevant Regulation for her not to be given a warning before her removal her from the practice list. The Practice did not provide me with any written record of the reason for removal given to the patient and the circumstances of the removal, as required by the Regulations. The only record provided to me was a copy of an undated letter issued to the complainant which advised her that she would be removed from the patient list and that the GPs felt that the patient doctor relationship had broken down. Prior to receiving this letter, there had been "strained" face to face and telephone encounters between the complainant and the Practice. The complainant had also been offered the opportunity of meeting with the Lead GP but declined the offer. Therefore, it was clear that she would have been aware that her relationship with the Practice was not as it should have been. That said, the letter advising her that she was to be removed from the Practice list was the first and only formal indication given to her that her behaviour was considered unacceptable.

My investigation concluded that the Practice did not adhere to the Regulations in removing the complainant from the Practice list. I recommended that the Practice provide her with a full written apology, in recognition of the stress, upset and inconvenience caused by its actions. I also recommended that the Practice review its approach to the removal of patients and its "Protocol for Removing a Patient from The Practice List" to ensure that it was compatible with the responsibilities placed on it by the Regulations. I did not find that the complainant was unable to have her regular bloods taken at the Practice or that her entire family had to leave the Practice list.

Treatment of Elderly Patient

This complaint concerns the care and treatment provided to the complainant's late elderly mother by a GP Practice prior to her admission to Loane House, South Tyrone Hospital in 2012. The complainant also made a separate complaint against the Southern Health and Social Care Trust (the Trust). The outcome of my investigation into the complaint against the Trust is contained in a separate report.

The complainant's mother was commenced on a particular pain relief drug by her GP. The drug was intended to be used for a trial period only, however the Practice issued a repeat prescription which, following contact by the family, was cancelled two days later. The complainant was concerned that the drug caused her mother to experience increased confusion, nausea and loss of appetite and that these adverse effects resulted from the interaction of the drug with her other medication and should not have been prescribed. The complainant also queried the appropriateness of her mother's admission, by the Practice, to Loane House rather than the local acute regional hospital i.e. Craigavon Area Hospital for investigation of her condition.

I did not uphold this complaint. Having considered the independent medical advice received, I concluded that the use of the pain relief drug was appropriate. I considered that the use of a repeat prescription rather an acute prescription to represent poor administrative practice but I welcomed the fact that the Practice has reviewed its prescribing policies to ensure that, in future, a consultation occurs routinely at the end of a drug trial period. I recommended that the Practice make an apology for issuing the repeat prescription and the Practice did so.

I was satisfied that the admission of the complainant's mother to Loane House was arranged for sound practical reasons in that she was admitted to the care of a Consultant Geriatrician whom she would have been familiar with and who was familiar with her and that direct admission avoided going through the local acute hospital's A&E and the possible delays associated with this type of admission.

Appendix C

2014-15 Workload and Performance

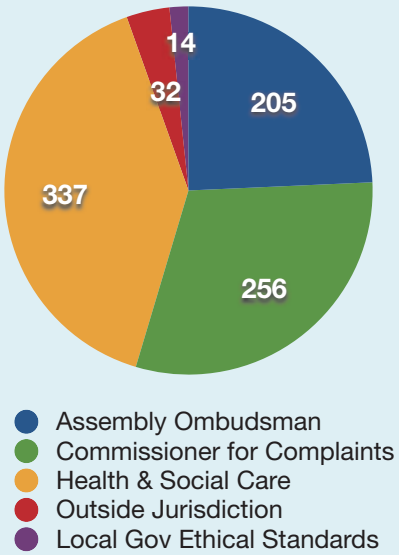
2014-15 Workload and Performance

During 2014-15, 2,607 members of the public contacted the Office. These contacts comprised 1,437 telephone enquiries, 340 written enquiries and 844 written complaints.

Of the 844 written complaints received, 205 were against bodies within the Ombudsman's jurisdiction as Assembly Ombudsman, 593 were against bodies within the Ombudsman's jurisdiction as Commissioner for Complaints, and 14 were complaints to the Commissioner against Councillors under Local Government Ethical Standards. The remaining 32 written complaints were found upon initial investigation to be outside the Ombudsman's jurisdiction.

Of the 593 Commissioner for Complaints' cases, 337 were against Health and Social Care (HSC) bodies and 256 were against other Public Bodies.

Breakdown of written Complaints to the Office 2014-15



During the year the Assembly Ombudsman reported on 121 issues of complaint. In 86 (71%) of these issues the complaint was upheld. In 35 (29%) of the issues no maladministration was found, though in 10 of these cases the Ombudsman was critical of the body complained of.

Agreed settlements between the complainant and the body complained of were achieved in 22 cases.

Accountability for our performance against the plans and targets that we set is an important aim of the Office. Our performance targets focus on the time taken to complete our investigations. Qualitative assessments are completed through established internal procedures. The Office's Key Performance Indicators (KPIs) are described below, followed by a discussion of the performance against these indicators in 2014-15.

- KPI 1: Measures how quickly we establish whether the complaint can be investigated by this Office. We aim to inform the complainant within 2 weeks or less of their complaint being received. The target is 90%;
- KPI 2: Measures how quickly we establish whether the complaint should be accepted for investigation by this office or whether it is suitable for early resolution. We aim to inform complainants of this decision within 8 weeks or less of their complaint being received. The target is 80%;
- KPI 3: Measures how quickly we complete the investigation of a complaint and issue a draft report to the body involved. We aim to complete this within 52 weeks or less of the decision being made to investigate. The target is 70%;
- KPI 4 (LGES): We will notify the complainant and the complained-against Councillor(s) within 4 weeks of receipt of a valid complaint of the decision whether or not to investigate. The target is 85%;
- KPI 4 was met in respect of **all** valid complaints received during 2014-15.

- KPI 5 (LGES): We will complete an investigation within 48 weeks of the date of the decision informing the complainant and the complained-against Councillor(s) that the complaint would be investigated. The target is 85%.

  The first LGES case was received in June 2014. As at the end of 2014-15 no investigations had reached the point where performance against this indicator could be assessed, so it is not yet applicable.

As already indicated, in 2014-15 the Office has been challenged to improve productivity despite an increased workload, a significant new jurisdiction (LGES) and preparing for the challenges around the smooth implementation of the NIPSO legislation. Throughout the year the focus has remained undiminished on maintaining the quality and depth of our casework, with a view to providing the best possible service to complainants and demonstrating our continuing commitment to the principles of fairness, justice and accountability.

Achievement against the KPIs in 2014-15 was mixed, reflecting a period of considerable change. KPI 1 was met in 84% of cases, narrowly falling short of the 90% target. The average number of days taken was 10, hence the average time to reach this "can we investigate" decision was within the performance target set.

The reported percentage performance for KPI 2 (the "should we investigate" decision) fell short more significantly. KPI 2 was met in 57% of cases against a target of 80% and the average number of days taken was 69. This was primarily due to workflow changes that have resulted in the ASSIST team applying a more robust approach to the application of the Investigation and Validation Criteria Policy. This in turn has led to a greater proportion of the preliminary investigation work on all cases being performed by ASSIST, before the "should we investigate" decision is made – with an inevitable knock-on effect on the time taken at this stage. As a result of this process improvement, KPI 2 is being reconsidered for 2015-16 with a view to extending the current target time of 8 weeks to reflect the revised and enhanced work process.

On the other hand, downstream from the "should we investigate" decision, the KPI 3 performance target has been comfortably exceeded. It was met in 79% of cases against a target of 70% and the average number of days taken was 233. This is reflective of the process improvements that are occurring in the earlier stages of the investigative process, which is assisting in addressing some of the developing pressure caused by increased case complexity that acts to drive clearance times upwards.

Following the changes to casework processes in 2014-15 the three KPIs have now been reviewed and refined for 2015-16.

Appendix D

Financial Summary 2014-15

Financial Summary 2014-15

The Assembly Ombudsman for Northern Ireland and the Northern Ireland Commissioner for Complaint's (AOCC) full Resource Accounts 2014-15 are due to be laid before the Northern Ireland Assembly in July 2015 and immediately afterwards will be available on our website at www.ni-ombudsman.org.uk.

Summary Financial Statements for the year ended 31 March 2015

The following Financial Statements are a summary of the information extracted from the AOCC's full annual Resource Accounts for 2014-15. The full annual Resource Accounts and auditors report should be consulted for further information.

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

Financial Review

For 2014-15 the Office set four financial management targets. The performance against each was as follows:

- KPI 6: We will not exceed the total Net Total Resource expenditure for the year authorised by the Northern Ireland Assembly as detailed in the 2014-15 Spring Supplementary Estimate, limiting any underspend to less than 2%;

  The Net Total Resource allocated to the Office for 2014-15 was £2.371 million. The actual net resource outturn equalled £2.261 million. Therefore, the actual amount of resource required was £110k less than the Estimate. This represented an underspend of 4.6% (3.6% in 2013-14)

  Of the £110k resource underspend £90k was as reduction in the provision established for legal fees against that forecast in the 2014-15 Spring Supplementary Estimates (SSE). This reduction materialised after the SSE exercise, due to direction from the Supreme Court as to when legal submissions were required. As such £90k of the provision became actual expenditure during 2014-15 resulting in an underspend against the forecast provision. Removing the provision underspend results in a £20k resource underspend (0.8%).

- KPI 7: We will not exceed the capital expenditure for the year authorised by the Northern Ireland Assembly, as detailed in the 2014-15 SSE, limiting any underspend to less than 2%;

  Actual capital expenditure amounted to £15k, which was £2k less than estimate figure.

- KPI 8: 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 2014-15 Spring Supplementary Estimate;

  The Net Cash allocation for the Office for 2014-15 was £1.968 million. The actual Net Cash requirement was £1.957 million, an underspend of £11k (0.6%) (2.4% in 2013-14).

- KPI 9: We will pay 98% 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 98% of payments (98% in 2013-14).

Staff costs for the year amounted to £1.342 million (see Note 3) compared with £1.193 million in the previous financial year. The increase in expenditure against the prior year is primarily due to the full staffing complement of the additional business area for local government ethical standards for the full reporting period. The remainder of the expenditure is split between property rent and rates, premises expenses, travel and subsistence, consultancy and other general office expenditure

Summary of Resource Outturn 2014-15

	2014-15 £000 Estimate			Outturn				2013-14 £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	2,371	-	2,371	2,261	-	2,261	110	1,919
Total resources	**2,371**	**-**	**2,371**	**2,261**	**-**	**2,261**	**110**	**1,919**
Non-operating cost AR	-	-	-	-	-	-	-	-

Net cash requirement 2014-15

	2014-15 £000			2013-14 £000
	Estimate	Outturn	Net total outturn compared with estimate: saving / (excess)	Outturn
Net cash requirement	1,968	1,957	11	1,903

Statement of Comprehensive Net Expenditure for the year ended 31 March 2015

	2014-15 £000				2013-14 £000
	Staff Costs	Other Costs	Income	Total	
Administration Costs (Request for resources A)					
Staff costs	1,342	-	-	1,342	1,193
Other administration costs	-	1,027	-	1,027	886
Operating income	-	-	-	-	(1)
Totals	**1,342**	**1,027**	**(1)**	**2,369**	**2,078**
Net Operating Cost				2,369	2,078

Statement of Financial Position
as at 31 March 2015

	2015	2014
	£000	£000
Non-current assets		
Property, plant and equipment	26	22
Intangible assets	23	47
Total non-current assets	49	69
Current assets		
Inventories	-	-
Trade and other receivables	98	109
Cash and cash equivalents	10	18
Total current assets	**108**	**127**
Total assets	**157**	**196**
Current liabilities		
Trade and other payables	(66)	(74)
Provisions	(260)	-
Total current liabilities	**(326)**	**(74)**
Non-current assets plus/less net current assets/liabilities	**(169)**	**122**
Non-current liabilities		
Provisions	-	-
Total non-current liabilities	**-**	**-**
Total assets less liabilities	**(169)**	**122**
Taxpayers' equity:		
General fund	(181)	109
Revaluation reserve	12	13
Total equity	**(169)**	**122**

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

My information leaflet is made widely available through the bodies within my jurisdiction; libraries; advice centres; etc. It is available: in large print form; and 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 RTKS-BAJU-ALEZ
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 complaints and details of the information available from my Office under our Publication Scheme.

Northern Ireland
Ombudsman

Northern Ireland Ombudsman
Distributed by and available from:
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