Northern Ireland
Ombudsman

Annual Report

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

2015 | 2016

My Role

As a result of the Public Services Ombudsman (Northern Ireland) Act 2016 the offices of Assembly Ombudsman for Northern Ireland and the Northern Ireland Commissioner for Complaints (AOCC) ceased to exist on 31 March 2016.

In 2015-16 those Ombudsman offices dealt with complaints from people claiming to have suffered injustice because of maladministration by government departments, their statutory agencies and a wide range of other public service providers in Northern Ireland. The term "maladministration" is not defined in legislation but includes unfairness, bias, avoidable delay or the misapplication of rules. In investigating a complaint of maladministration, the "Principles of Good Administration" (see Appendix A) provide a framework against which the actions of bodies can be examined for failure to follow policies or procedures.

Since June 2014, in the role of Northern Ireland Commissioner for Complaints, the Ombudsman has had powers to investigate complaints about alleged breaches of the Local Government Code of Conduct for Councillors (the Code). In that role the Ombudsman adjudicates on the relevant sanctions to be applied, where a breach of the Code has been found.

In addition to complaints of maladministration about central and local government, housing, planning and education, I can investigate complaints about Health and Social Care as well as complaints about publicly funded health and social care provided by a private body. An Ombudsman is not a court and, in relation to complaints about alleged medical negligence, this is a matter for the Courts.

My role is independent of the public service providers which I have the power to investigate. All complaints to me are treated in the strictest confidence, and the service I provide is free.

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ANNUAL REPORT

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

2015-16

Presented to the Assembly pursuant to Schedule 2
of the Public Services Ombudsman Act (Northern Ireland) 2016

Contents

		Page
GLOSSARY OF TERMS		6
SECTION 1	The Year in Review	7
SECTION 2	Report on the Work of the Advice, Support Service and Initial Screening Team (ASSIST)	13
SECTION 3	Annual Report of the Assembly Ombudsman for Northern Ireland	17
	Complaints Statistics	20
SECTION 4	Annual Report of the Northern Ireland Commissioner for Complaints (excluding complaints about Health & Social Care)	25
	Complaints Statistics	26
SECTION 5	Annual Report of the Northern Ireland Commissioner for Complaints (Health & Social Care complaints)	33
	Complaints Statistics	36
SECTION 6	Annual Report of the Northern Ireland Commissioner for Complaints – Local Government Ethical Standards	41
Appendix A:	Principles of Good Administration	49
Appendix B:	Selected Case Summaries	51
Appendix C:	2015-16 Workload and Performance	71
Appendix D:	Financial Summary 2015-16	75

Glossary
of Terms

AOCC	Assembly Ombudsman/ Commissioner for Complaints
ASSIST	Advice, Support Service and Initial Screening Team
BHSCT	Belfast Health and Social Care Trust
CPN	Community Psychiatric Nurse
DHSSPS	Department of Health, Social Services & Public Safety
DOE	Department of the Environment
DVA	Driver & Vehicle Agency
ED	Emergency Department
FE/HE	Further Education/ Higher Education
FPN	Fixed Penalty Notice
GP	General Practitioner
HMRC	Her Majesty's Revenue & Customs
HSC	Health and Social Care
ICPCC	Initial Child Protection Case Conference
IPA	Independent Professional Advice
KPI	Key Performance Indicator
LGES	Local Government Ethical Standards
LPS	Land & Property Services
MLA	Member of the Legislative Assembly
NHSCT	Northern Health and Social Care Trust
NIAO	Northern Ireland Audit Office
NICS	Northern Ireland Civil Service
NIHE	Northern Ireland Housing Executive
NIJAC	Northern Ireland Judicial Appointments Commission
NIJAO	Northern Ireland Judicial Appointments Ombudsman
NILGCS	Northern Ireland Local Government Commissioner for Standards
NIPSO	Northern Ireland Public Services Ombudsman
OFMdFM	Office of the First Minister and Deputy First Minister
PAC	Planning Appeals Commission
PLGG	Planning and Local Government Group (within DOE)
PSNI	Police Service of Northern Ireland
RBHSC	Royal Belfast Hospital for Sick Children
RVH	Royal Victoria Hospital
SAI	Serious Adverse Incident
SHSCT	Southern Health and Social Care Trust
WHSCT	Western Health and Social Care Trust

Section One
The Year in Review

Section One

I am pleased to present this Annual Report of the offices of the Assembly Ombudsman for Northern Ireland and Northern Ireland Commissioner for Complaints. This report is laid before the Northern Ireland Assembly as the final document of record for these two statutory offices that have been in existence since 1969.

It is significant that I lay this record on behalf of my predecessor, Dr Tom Frawley CBE, who held both offices from 1 September 2000 to 31 March 2016. I would like to take this opportunity to record my gratitude to Dr Frawley on his selfless service and exemplary commitment to this Office as Assembly Ombudsman and Commissioner for Complaints for over fifteen and a half years. Dr Frawley as Ombudsman was held in high regard and his sound judgment and sense of fairness brought consistency to his decisions for the benefit of the citizens and the staff in the bodies in jurisdiction. His tenure in office saw many changes, both jurisdictional (with the introduction of the Local Government Ethical Standards regime) and structural (with the creation of the Assist Team to advise, assess and select cases for resolution or investigation). On a personal note, as Dr Frawley's deputy since May 2009, I will miss his guidance, humour and humanity as will all staff in my Office.

New Ombudsman Legislation

Throughout the reporting year 2015-16 the Ombudsman and staff were preparing for the implementation of legislation to modernise and reform the office which has now been enacted as the Public Services Ombudsman (Northern Ireland) Act 2016 (the 2016 Act). The 2016 Act received Royal Assent on 19 February 2016 and was a major piece of primary legislation that, uniquely, was developed and supported by the former OFMdFM Committee of the Northern Ireland Assembly. The 2016 Act extends the number of bodies in the jurisdiction of my office and increases my investigation powers. For instance, from 1 April 2016 bodies such as the Northern Ireland Audit Office and Northern Ireland Assembly Commission come within jurisdiction as will all regional colleges, universities and other affiliated colleges in October 2016. From 1 April 2016 the functions of the Northern Ireland Judicial Appointments Ombudsman (NIJAO) transferred to my office. Over the next two years my remit will further extend with complaints about the decisions of Boards of Governors of all publicly funded schools coming into jurisdiction in April 2017. From April 2018 I will have power to investigate on my own initiative.

The new legislation is very much the legacy of my predecessor, Dr Tom Frawley CBE, as he had been advocating for the changes since the Deloitte Review Report on the modernisation of the office was first published in 2004. In 2010 the OFMdFM Committee agreed to sponsor the new legislation framework to modernise the office and ensure that the Northern Ireland's Ombudsman remit was a 'one-stop shop' for complaints about public services. May I take this opportunity to thank the former Speaker (Mr Mitchel McLaughlin) and Clerk of the Assembly (Mr Trevor Reaney) as well as their staff at the Assembly Commission for providing the essential leadership resources necessary to achieve this long awaited legislative change. A significant contribution was also made by the former Chair (Mr Mike Nesbitt MLA), members and staff of the OFMdFM Committee. Without their dedication and commitment this significant legislation would not have been possible. The 2016 Act is now an exemplar for other Ombudsmen's offices in the devolved jurisdictions and ensures that members of the public can complain to my Office about the full range of public services.

NIPSO Implementation

In January 2015 the Ombudsman established a NIPSO Implementation Team chaired by me as Deputy Ombudsman to ensure that the organisational, structural and operational measures were established in preparation for NIPSO commencement on 1 April 2016. Each member of the Senior Management Team took the lead in one of the following working groups:

- Communications
- Governance and Accountability
- Organisational Development and Human Resources (ODHR)
- Staff Engagement
- Processes and Procedures
- Website

The working groups established agreed terms of references and a work programme. All Office staff participated in at least one of the working groups and their enthusiasm and commitment has been both notable and commendable. At monthly meetings with the group leaders the Deputy Ombudsman discussed progress and set next steps. Progress was reported at Operational, Senior Management and Audit Committee meetings. Independent scrutiny and assurance was provided by our internal auditors who considered the structural proposals and provided advice on the proposed NIPSO scheme as well as commentary on proposed new NIPSO governance structures.

NIPSO Communications Working Group

Emerging from the Communication actions plan and the final Assembly approval of the 2016 Act was the need to hold a workshop dedicated to NIPSO communication. This was held on 3 March 2016 and was facilitated by the Scottish Public Services Ombudsman (SPSO) Communications and Policy Manager, Ms Emma Gray. The workshop focused on reporting under the new NIPSO legislation with an emphasis on increased use of 'reports' to communicate essential learning from complaints to the 'listed authorities' and the public. I am very grateful to Emma for her sound advice and support of our proposals for stakeholder communication and engagement.

Governance and Accountability

Led by the Director of Finance and Corporate Services, this group focused on accountability and governance arrangements for the new NIPSO office. A key part of the work was to consider the establishment of relationships with the Northern Ireland Assembly Audit Committee. A draft Memorandum of Understanding was developed to be taken forward with the new Assembly Audit Committee under the new 2016-2020 Assembly mandate. This working group suggested governance models for the new NIPSO Audit and Risk Committee and for increased delegated authority including financial delegations.

Organisational Development and Human Resources (ODHR)

Key to successful NIPSO implementation was the work of the ODHR working group. During the year significant and timely progress was made in the complex and challenging area of staff transfer. This project had several interrelated strands including the development of NIPSO employee terms and conditions and HR policies and processes, thus ensuring a smooth transfer of AOCC staff to NIPSO. In addition to the significant progress made by this group there have been a number of recruitment challenges emerging as a result of the NICS Voluntary Exit Scheme and staff choosing to leave for other posts in this reporting year. I wish these former staff well in their future careers and am grateful for their contributions to the NIPSO implementation groups.

Processes and Procedures Working Group

The 2016 Act provides for extensions of remit that require significant operational change with particular focus on ASSIST processes to ensure that the new bodies will come into jurisdiction from 1 April 2016 (NIJAC, NIAO, Assembly Commission), October 2016 (FE/HE) and 1 April 2017 (schools). A key provision of the 2016 Act is the requirement that complaints must be signposted to NIPSO after exhaustion of the internal complaints process. Following this a complaint must be brought to NIPSO within six months and NIPSO will have discretion to extend this time in special circumstances. The legislative change has highlighted the need to train and develop all staff to ensure the necessary knowledge and skills. An extensive refresh and refocus programme of training was completed in 2015 and training on the Ombudsman's approach to human rights related issues is ongoing.

Website Working Group

The creation of the new NIPSO office was an opportunity to refresh the office website. A key task was to create three separate sub-websites under the overall NIPSO site, reflecting the distinct roles of Public Services Ombudsman, Northern Ireland Local Government Commissioner for Standards and the NIJAO function. The website is an essential tool to enable external communication under NIPSO. The new website has an online complaint form to facilitate members of the public in making complaints to the office as well as detailed information on how to make a complaint. The website went live on 1 April 2016 and has been commended for its clarity and accessibility.

AOCC Casework and Statistics

In this year, complaints to the Office reduced by 11% from the 2014-15 reporting year. However, over the past five years, since 2011-12, there has been an overall increase of 16%. In 2015-16 a total of 3,057 members of the public contacted the Office which is a significant increase of 72% on the previous year. Most of these contacts were made by telephone (1,954). Of the total contacts, 742 were complaints of maladministration. Notably, 56% of these complaints were upheld. The continuing dominance of complaints about health and social care issues has again been evident. Of the 742 maladministration complaints received in 2015-16, 45% related to this sector. In this year also, 23% related to the actions of government departments and their statutory agencies. In recent years, complaints about Northern Ireland Departments have notably reduced. This reduction, as reported in previous annual reports, is due (in my view) to the focus on improving complaint handling across the departments, led by the Head of the Civil Service and the Permanent Secretaries Group, for which I commend the NICS.

Local Government Ethical Standards

From June 2014 the Office has undertaken the role of investigating and adjudicating on complaints about alleged breaches of the Local Government Code of Conduct for Councillors. During 2015-16 a total of 33 complaints were received and nine were carried forward from 2014-15. The total number of complaints under investigation under the Code was 42. In relation to these complaints, 1 was withdrawn, 28 were closed during the assessment process and 3 investigation reports were issued. At the end of the 2015-16 reporting year, 10 Code of Conduct complaints remained under investigation. A separate report on the work of the Local Government Ethical Standards Directorate is provided later in this report.

Significant Cases

The case summaries in this report highlight some very distressing cases, particularly in relation to failings in healthcare. These cases can be found at Appendix B to this report. Of particular note is a major investigation in relation to the treatment of a patient with mental health problems in the Belfast Health and Social Care Trust Emergency Department (ED). Sadly the patient had taken a fatal overdose of his prescribed medication. It is evident that he was a much loved son and brother and his family had given him a high level of support with his mental health issues. Of particular concern was the lack of follow up from community psychiatric services when his mother alerted them to her son's declining mental health.

His family sought answers as to how his death had occurred. My investigation established that the death was a shock to ED staff as they had no information from the specialist poisons information service on the risk that the overdose could be fatal. Staff had failed to carry out hourly observations. Therefore the clinicians were not fully informed about his condition, thus missing an opportunity to assess the patient. This investigation also revealed failings in how the family's complaint was handled and in the Serious Adverse Incident (SAI) process.

In this and two other health cases in 2015-16 I have found failings in how HSC Trusts dealt with SAIs. This concerns me because SAI investigations allow the learning from such incidents to be captured and shared so as to improve patient safety. In light of these cases, I intend to proactively engage with the HSC sector to improve its capacity to share the learning from SAI investigations and from complaints.

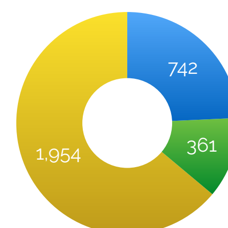
Conclusion

May I take this opportunity to thank all staff for their contributions to maintaining on-going caseloads whilst preparing for the new legislation. I was impressed by their energy and commitment and without their hard work the successful transition to NIPSO would not have been achieved.

Statistics

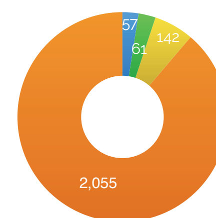
Number of Contacts regarding maladministration 2015-16

Enquiries - Written	–	361
Enquiries - Telephone	–	1,954
Total Enquiries	**–**	**2,315**
Written Complaints	–	742
Total Contacts	**–**	**3,057**



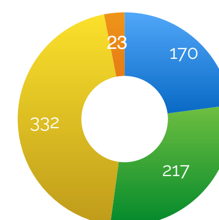
Breakdown of Enquiries to the Office 2015-16

Assembly Ombudsman	–	57
Commissioner for Complaints	–	61
Health and Social Care	–	142
Outside Jurisdiction[1]	–	2,055
Total	**–**	**2,315**

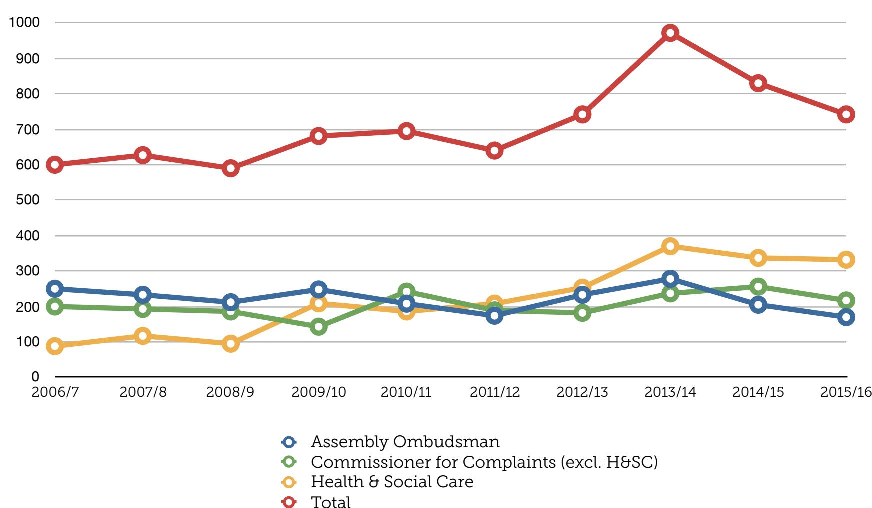


Breakdown of Written Maladministration Complaints to the Office 2015-16

Assembly Ombudsman	–	170
Commissioner for Complaints	–	217
Health and Social Care	–	332
Outside Jurisdiction	–	23
Total	**–**	**742**



Maladministration Complaints Received 2006-07 to 2015-16



1 Complaints are outside jurisdiction if they are not related to bodies or matters that I can investigate.

Section Two

Report on the work of the Advice, Support Service and Initial Screening Team (ASSIST)

The Advice, Support Service and Initial Screening Team (ASSIST) was established in May 2013 and is the first contact for all members of the public with my Office. The team consists of 3 Casework Officers, 3 Investigating Officers and a Senior Investigating Officer and it plays an important role in providing advice to those who want to pursue a complaint. Importantly, ASSIST is key to ensuring that I focus my resources effectively and provide a high level of customer service by promptly informing complainants about action my Office can take regarding their complaint. This team also provides valuable advice for complainants and their representatives on how to complain about public services.

ASSIST deals with a variety of complaints. I am not required to investigate every complaint I receive. ASSIST assesses all complaints of maladministration about public services and considers what, if any, action can be taken to resolve the complaint. Initially a complaint is assessed to establish if I have the jurisdiction to accept it, using the legislation which governs my role. Where it is clear I cannot accept a complaint, ASSIST staff clearly explain to the complainant how this decision has been reached by reference to that legislation.

It is important that complainants are fully informed of the decision about their complaint as soon as possible so that they can pursue other recourse available to them. Where appropriate, ASSIST staff signpost complainants to other ombudsmen or organisations who may be able to investigate their issue. In 2015-16 ASSIST assessed 742 written complaints and responded to complainants with an initial assessment decision within 2 weeks in 95% of cases. This performance is noteworthy as it exceeds the target of 90%.

Having made the initial 'can we investigate' decision, in 215 cases a further assessment was then completed to decide if I should investigate the complaint. At this point the ASSIST team use my Validation and Investigation Criteria to decide if:

(1) An investigation is appropriate and necessary in the circumstances (a Proportionality test)

(2) An investigation by the Ombudsman would directly bring about a solution or adequate remedy (a Practical outcome test)

(3) Investigating the issues of complaint could be of potential benefit to the general public (a Public interest test).

ASSIST aim to arrive at the 'should we' decision within 10 weeks. In 2015-16 ASSIST were able to provide the complainant with a response within this time in 76 % of cases. This performance also is noteworthy given that it exceeds the target of 70%.

Settlements

Legislation provides me with a discretion to attempt to effect a fair settlement of a complaint in cases where I consider that it is desirable to do so. Whilst assessing complaints, my ASSIST staff always offer the body complained of the opportunity to put forward any proposals for a settlement of the complaint. Where a body offers a settlement proposal, this is then considered as part of the assessment process. Alternatively, I can also decide to attempt to settle a complaint as a result of consideration of the information gathered during the assessment process. Settlement of a complaint provides a speedy, effective and practical resolution of the complaint without recourse to a full investigation which can be lengthy. This can be a 'win win' both for the body and the complainant, who often simply wants the issue to be resolved quickly.

When considering the possible settlement of a complaint, ASSIST staff identify action to remedy the problem at the heart of the complaint. This may take the form of more effective or timely service provision by the body complained of, an apology, reimbursement of expenses or service changes. ASSIST staff then put forward settlement proposals to the body and allow the opportunity to reach agreement.

During 2015-16 the team settled 26 cases. Examples of these settlements include a refund of fees paid to the Planning Appeals Commission (PAC), incurred because of an administrative error by the Department of the Environment – Planning and Local Government Group. I am pleased to note that the Chief Planner agreed to refund the fees. I welcome this pragmatic approach by the Department to achieving early resolution.

Another example involved expenses incurred by a tenant in replacing a faulty front door to her Housing Association property. The complainant considered that a refund was appropriate. During the assessment of this complaint, it was noted that the complainant was not eligible for any such payment under the Housing Association's current policy. However, following a request for settlement proposals from my Office, I was pleased that the Chief Executive of the Housing Association fully reviewed the case and offered the complainant an apology for distress and inconvenience and a payment of £200. This was in recognition that further advice could and should have been provided to the tenant prior to the installation of her new door.

Another complaint where a settlement was effected was made by a prisoner who was concerned about a lack of healthcare in relation to a number of ongoing health problems he was experiencing. He felt that there had been delays in appointments and he was unsure how his treatment should be progressing. In response to my ASSIST staff, the South Eastern Health & Social Care Trust (Prison Healthcare) offered a settlement proposal. It was agreed that the Operational Nurse Manager for Prison Healthcare would meet with the complainant to fully discuss each element of his health complaint. Following this meeting, a written summary was provided which identified the appropriate medical referrals and treatment required. In addition, the Trust agreed to apologise to the complainant for the delay in providing him with a consistent and timely response to his concerns.

In a further case I received a complaint about a Council's management and investigation of an incident at a leisure centre involving a member of staff and a member of the public during a summer scheme. The complainant stated that his concerns had not been fully investigated or addressed and, as a result, he felt that he and his family could no longer use the facility. In response to my ASSIST staff's settlement enquiries, I am pleased to state that the Council acknowledged that this complainant should have been given a full refund of all monies paid for the summer scheme. In addition, the Council offered the complainant an apology for the manner in which his complaint had been handled and also offered a complimentary voucher for 15 adult and 15 child swims to encourage their re-attendance and to restore their confidence in using the leisure centre. In achieving agreement to this settlement proposal, I was also satisfied that the wider public interest was served in this case as the Council undertook to review its child protection policy in relation to complaints handling as well as implementing ongoing child protection training for all staff.

Review of decisions

Where a decision is made that a complaint should not be accepted for investigation, the complainant can request an internal review of that decision. The review is completed by a senior officer independent of the initial decision and involves a comprehensive review of all information which informed the decision. This may involve further information gathering. This is often a time consuming process, however I consider that it is appropriate that the fullest consideration is given to such requests to ensure that the ASSIST decisions are fair and objective. A total of 35 requests for review of ASSIST decisions were made in 2015-16, which resulted in nine cases being re-opened.

Preparation for NIPSO

As noted earlier in this report, the Office of the Northern Ireland Public Services Ombudsman (NIPSO) was established on 1 April 2016. The ASSIST team played a key role in developing and sharing information about NIPSO to the public and all new bodies in jurisdiction. This involved reviewing and updating all of our publicly available information including leaflets, publications and website content. ASSIST continues to provide timely and valuable advice to the public seeking help and information on the role of NIPSO.

Section Three

Annual Report of the Assembly Ombudsman for Northern Ireland

As Assembly Ombudsman I investigate complaints of maladministration about government departments and their statutory agencies, sponsored by MLAs. I received a total of 170 such complaints in 2015-16 and 115 of these complaints concerned the actions and decisions of government departments.

Regarding government departments, the December 2014 Stormont House Agreement included a commitment to reduce the number of Departments from twelve to nine. In November 2015 the 'Fresh Start' agreement confirmed the reallocation of functions in the new nine-departmental structure, which came into effect on 9 May 2016. Cases ongoing in my Office at 31 March 2016 will be reassigned to the appropriate new Department for 2016-17. However, where applicable this report refers to the department names that applied during 2015-16.

In previous reporting years the Department about which I received the highest number of complaints was the Department of the Environment, the majority of these concerning the Planning and Local Government Group (PLGG). This year I received 25 complaints concerning PLGG, which on the face of it is a 50% decrease from last year. I attribute this to the fact that in April 2015 most planning functions were transferred to Councils as part of local government reform. Responsibility for dealing with complaints about planning generally now lies with Councils, apart from a limited number of circumstances. This change in responsibility is reflected in the fact that 33 planning complaints in relation to Council decisions were made to my Office in 2015-16. Combined with the 25 complaints regarding PLGG this represents a 16% increase on the total of 50 for 2014-15. This continuing trend in complaint numbers indicates to me that the public remain concerned about the planning process and decision makers.

Many complaints of maladministration arise from the failure of the body concerned to have in place effective or appropriate policies or procedures and in some cases to follow their own policies. Two cases which I reported on this year highlight this.

Failure to have adequate policies or procedures in place or to follow established policies or procedures

The first complaint, sponsored by Jonathan Bell MLA, was in relation to the collection of rates by the Land and Property Services (LPS) which is part of the Department of Finance and Personnel. My investigation established that LPS failed to amend a tenant's rate account in October 2010, when provided with information that it was a rental rather than owner occupied property. LPS subsequently failed to follow its own procedures in relation to processing the tenant's application for a rate refund which resulted in a loss of almost £2,900 to public funds. Although significant changes to rates affecting landlords and tenants took effect on 1 April 2007 which placed the onus on LPS to ensure that the rate bill was 'levied on' the right person, LPS failed to formulate plans to publicise these changes in sufficient time for the 2007-2008, 2008-2009 and 2009-2010 billing cycles. In this case the landlord was unaware of his responsibility for the rates, which has previously rested with the tenant under the tenancy agreement. As a consequence of this maladministration, the complainant who owned the property received an unexpected backdated rate demand for £3,269 for the period 1 April 2007 to 31 March 2013.

In response to a complaint made to LPS a portion of the arrears was written off under its procedure for Shortfall in Services. My investigation revealed that LPS were unaware of the number of rental properties that were incorrectly recorded as 'owner occupied' and as such LPS could not be certain that the rate bill was being levied on the right person. Following my investigation, which found maladministration in the processing of the rates account, I recommended that LPS should write off the remaining liability of the complainant's rate account, an amount of £1,278. I also recommended that the Chief Executive (CE) issue a letter of apology for the failures detailed in my report. The CE also informed me that LPS have been working to identify accounts where the rating liability may not be correct and that this work will continue.

I also wish to highlight a complaint, sponsored by Anna Lo MLA, about the Office of the First Minister and Deputy First Minister (OFMdFM) regarding the administration of a grants process. A voluntary body had successfully applied to OFMdFM for a grant. In May 2013, after accepting an OFMdFM letter of offer, the group was separately informed that another funder had approved full funding for the same project. In light of this potential double funding the body sought to re-allocate the OFMdFM funding to another strand of the project and was advised to resubmit their application. OFMdFM treated this resubmitted application as if it were a new application. As a result of lower scoring, the application failed and the entire grant was withdrawn.

I found that there was no provision within the rules for OFMdFM to request resubmission of the application. I was also critical that the organisation was not offered an alternative to resubmitting the application. It should have been advised to submit a request for variation in writing and ought to have received a response in writing from OFMDFM. I was also critical that the rationale for several major decisions were not recorded.

The organisation appealed the OFMdFM decision. The Appeals Panel recommended that OFMdFM should undertake a review of the case by a senior official who had not been involved in the process. I considered this recommendation to be proportionate and in keeping with the Principles of Good Administration and I was critical that it was not pursued. I found that the body had been encouraged by OFMdFM to pursue a flawed process for almost 8 months before being belatedly informed that there was no scope to take the matter further. I upheld the complaint and made recommendations in relation to improved record keeping and review of the relevant internal guidance manual. I also recommended that OFMdFM make an apology and a payment of £5,000 in respect of the upset, inconvenience, frustration, delay and loss of opportunity.

Complaints Statistics

In 2015-16 my Office received a total of 170 written complaints about government departments and their statutory agencies; 17% fewer than the previous year. This is evidence of the continuing downward trend in this jurisdiction. The breakdown of these complaints is as follows:

Statistical Information – Assembly Ombudsman Cases

Written Complaints Received in 2015-16 by Authority Type

Government Departments	115
Statutory Agencies	25
Northern Ireland Prison Service	21
Northern Ireland Courts & Tribunals Service	5
Statutory Tribunal	3
North-South Implementation Body	1
Total	**170**

Recommendations in Reported and Settled Cases 2015-16

Case No	Body	Recommendation
13884	Department of the Environment - Planning and Local Government Group	Apology and payment of £700
14058	Department of the Environment - Planning and Local Government Group	Apology and payment of £4,000
14166	Department of Enterprise, Trade & Investment	Apology and payment of £500
14300	Department of Finance & Personnel - Land & Property Services	Apology and writing off of rates of £1,278
14340	Department of the Environment - Planning and Local Government Group	Apology and payment of £250
14506	Department of Agriculture & Rural Development	Payment of £14,612
14643	Northern Ireland Prison Service	Apology and payment of £350
15091	Department for Social Development - Child Maintenance Service	Apology and payment of £500
15204	Office of the First Minister and Deputy First Minister	Payment of £5,000
15477	Driver & Vehicle Agency	Apology, payment of £50 and Service Improvement
15512	Department of the Environment - Planning and Local Government Group	Apology, payment of £1,300 and Service Improvement
15542	Department of Agriculture & Rural Development	Apology and payment of £1,500
15616	Northern Ireland Prison Service	Apology and Service Improvement
15618	Department of Finance & Personnel - Land & Property Services	Apology and Service Improvement
15810	Department of the Environment - Planning and Local Government Group	Payment of £126
16105	Department of Finance & Personnel - Land & Property Services	Reduction of rates
16287	Office of the First Minister and Deputy First Minister	Payment of £1,750

Analysis of Written Complaints Determined in 2015-16

	Brought Forward @ 1/4/15	Complaints Received in 2015-16	Determined at KPI* 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/16
Government Departments	25	115	71	37	15	17
Agencies of Government Departments	1	25	20	2	1	3
North-South Body	0	1	1	0	0	0
Tribunal	1	3	2	2	0	0
Other Bodies Within Jurisdiction	4	26	20	5	2	3
Total	**31**	**170**	**114**	**46**	**18**	**23**

* For explanations of "KPIs" see Appendix C

Analysis of Written Complaints against Government Departments (as existing during the reporting year)

	Brought Forward @ 1/4/15	Complaints Received in 2015-16	Determined at KPI 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/16
DRD	0	15	10	4	0	1
DSD	0	12	9	2	0	1
DSD – CMS	1	4	3	1	1	0
DARD	1	18	12	6	1	0
DCAL	0	3	2	0	0	1
DE	1	2	2	0	1	0
DEL	0	4	3	1	0	0
DETI	1	1	1	0	1	0
DFP	0	3	2	0	0	1
DFP – LPS	5	10	5	5	3	2
DOJ	0	3	3	0	0	0
DOJ – CS	0	0	0	0	0	0
DOE	0	7	4	1	0	2
DOE – PLGG	15	24	11	14	6	8
OFMdFM	1	9	4	3	2	1
Total	**25**	**115**	**71**	**37**	**15**	**17**

Analysis of Written Complaints against Statutory Agencies

	Brought Forward @ 1/4/15	Complaints Received in 2015-16	Determined at KPI 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/16
Driver & Vehicle Agency	1	7	5	2	1	0
General Register Office	0	1	1	0	0	0
Northern Ireland Environment Agency	0	1	0	0	0	1
Rivers Agency	0	2	1	0	0	1
Social Security Agency	0	14	13	0	0	1
Total	**1**	**25**	**20**	**2**	**1**	**3**

Analysis of Written Complaints against North-South Bodies

	Brought Forward @ 1/4/15	Complaints Received in 2015-16	Determined at KPI 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/16
Special European Union Programmes Body	0	1	1	0	0	0
Total	**0**	**1**	**1**	**0**	**0**	**0**

Analysis of Written Complaints against Tribunals

	Brought Forward @ 1/4/15	Complaints Received in 2015-16	Determined at KPI 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/16
Planning Appeals Commission	1	3	2	2	0	0
Total	**1**	**3**	**2**	**2**	**0**	**0**

Analysis of Written Complaints against Other Bodies within Jurisdiction

	Brought Forward @ 1/4/15	Complaints Received in 2015-16	Determined at KPI 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/16
Northern Ireland Courts & Tribunals Service	0	5	5	0	0	0
Northern Ireland Prison Service	4	21	15	5	2	3
Total	**4**	**26**	**20**	**5**	**2**	**3**

Section Four

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

The jurisdiction of the Commissioner for Complaints covers a wide range of bodies in Northern Ireland that deliver public services. This involves complaints about the provision of social housing, education services provided by the Education Authority and services provided by local councils as well as a wide range of other bodies. Regarding 2015-16, one of the notable changes in this jurisdiction is the addition of complaints of maladministration about processing and decision making in the majority of planning applications. This change arises from the transfer of planning powers to local government on 1 April 2016 as part of the reform of local government and the establishment of eleven councils.

A significant number of complaints made under the jurisdiction of the Commissioner for Complaints relate to health and social care providers. Given the extent of complaints about this sector detail of these cases can be found separately in Section 5 of this report.

As reported elsewhere I have recorded a decrease in the number of complaints received this year across all my jurisdictions. I received 217 complaints under my Commissioner for Complaints jurisdiction (excluding complaints about care and treatment in health and social care) a reduction of 15% from 2014-15. This is despite the transfer of planning powers to local government. Complaints about planning would previously have been reported in my jurisdiction as Assembly Ombudsman. In total I received 82 complaints about local councils; this is a slight reduction from the 85 received in 2014-15. I am pleased to note this reduction in complaints concerning local government, particularly in light of the added planning responsibilities in the sector. My staff had engaged with the local government sector during the year to explain my role and promote good practice in complaint handling. I believe that there is a continued focus by the sector on valuing complaints from citizens, focusing on early resolution and learning from complaints; themes which I consider to be very important.

I have noted a 60% reduction in complaints against health and social care bodies not related to clinical care and treatment and a 12% reduction in complaints concerning the education authority. I however received 11% more complaints concerning housing bodies.

Complaints Statistics

As stated above, in 2015-16 my Office received a total of 217 written complaints under my Northern Ireland Commissioner for Complaints jurisdiction (excluding complaints about Health and Social Care). This is 39 fewer than the previous year. The breakdown of these complaints is as follows:

Written Complaints Received in 2015-16 by Authority Type

Education Authority	22
Health & Social Care Bodies*	10
Housing Bodies	90
Local Councils	82
Other Commissioner for Complaints	13
Total	**217**

* Please note that this relates to complaints about HSC bodies about issues **other than** clinical care and treatment.

Recommendations in Reported and Settled Cases 2015-16

Case No	Body	Recommendation
13888	Armagh City, Banbridge & Craigavon Borough Council	Apology
13902	Education Authority	Apology and payment of £1,000
14296	Northern Ireland Housing Executive	Apology and Service Improvement
14433	Choice Housing	Other
14693	Armagh City, Banbridge & Craigavon Borough Council	Apology and Service Improvement
14919	Limavady Borough Council	Apology and payment of £800
15116	Education Authority	Apology and Service Improvement
15224	Fold Housing Association	Apology and Service Improvement
15328	Northern Ireland Legal Services Commission	Apology and payment of £8,000
15351	Probation Board for Northern Ireland (PBNI)	Apology
16249	Habinteg Housing Association (Ulster) Ltd	Apology and payment of £200

Analysis of Written Complaints Determined in 2015-16

	Brought Forward @ 1/4/15	Complaints Received in 2015-16	Determined at KPI* 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/16
Education Authorities	2	22	18	4	2	0
Health & Social Care Bodies	1	10	4	4	0	3
Housing Authorities	3	90	73	13	2	5
Local Councils	10	82	59	21	4	8
Other CC	5	13	10	2	4	2
Total	**21**	**217**	**164**	**44**	**12**	**18**

* For explanations of "KPIs" see Appendix C

Analysis of Written Complaints about Education Authorities

	Brought Forward @ 1/4/15	Complaints Received in 2015-16	Determined at KPI* 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/16
Council for Catholic Maintained Schools	0	3	3	0	0	0
Education Authority	2	19	15	4	2	0
Total	**2**	**22**	**18**	**4**	**2**	**0**

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

	Brought Forward @ 1/4/15	Complaints Received in 2015-16	Determined at KPI* 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/16
Business Services Organisation	0	1	1	0	0	0
Northern Health & Social Care Trust	0	2	1	0	0	1
Northern Ireland Ambulance Service Trust	0	5	1	3	0	1
South Eastern Health & Social Care Trust	1	2	1	1	0	1
Total	**1**	**10**	**4**	**4**	**0**	**3**

Analysis of Written Complaints about Housing Authorities

	Brought Forward @ 1/4/15	Complaints Received in 2015-16	Determined at KPI* 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/16
Choice Housing	0	13	10	2	0	1
Clanmil Housing Association Ltd	0	1	1	0	0	0
Fold Housing Association	1	6	6	0	1	0
Habinteg Housing Association (Ulster) Ltd	0	3	2	1	0	0
HELM Housing	0	4	4	0	0	0
Northern Ireland Co-Ownership Housing Association	0	1	1	0	0	0
Northern Ireland Housing Executive	2	61	48	10	1	4
Oaklee Homes Group	0	1	1	0	0	0
Total	**3**	**90**	**73**	**13**	**2**	**5**

Analysis of Written Complaints about Local Councils

	Brought Forward @ 1/4/15	Complaints Received in 2015-16	Determined at KPI* 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/16
Antrim & Newtownabbey Borough Council	0	5	3	2	0	0
Ards & North Down Borough Council	0	6	4	1	0	1
Armagh City, Banbridge & Craigavon Borough Council	5	11	10	5	0	1
Belfast City Council	0	18	11	6	0	1
Causeway Coast & Glens Borough Council	2	5	4	0	2	1
Derry City & Strabane District Council	0	4	1	1	1	1
Fermanagh & Omagh District Council	1	1	1	0	1	0
Lisburn & Castlereagh City Council	0	6	3	2	0	1
Mid & East Antrim Borough Council	0	10	10	0	0	0
Mid Ulster District Council	0	3	2	1	0	0
Newry, Mourne & Down District Council	2	13	10	3	0	2
Total	**10**	**82**	**59**	**21**	**4**	**8**

Analysis of Written Complaints about Other Bodies within Jurisdiction

	Brought Forward @ 1/4/15	Complaints Received in 2015-16	Determined at KPI* 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/16
Arts Council	1	0	0	0	1	0
Charity Commission for Northern Ireland	0	4	3	0	0	1
Consumer Council	0	1	0	1	0	0
Equality Commission for Northern Ireland	1	1	1	0	1	0
Health & Safety Executive	0	2	1	0	0	1
Invest NI	0	1	1	0	0	0
Legal Services Agency Northern Ireland	0	1	1	0	0	0
Northern Ireland Fire and Rescue Service	1	1	2	0	0	0
Northern Ireland Legal Services Commission	1	0	0	0	1	0
Northern Ireland Policing Board	0	2	1	1	0	0
Probation Board for Northern Ireland	1	0	0	0	1	0
Total	**5**	**13**	**10**	**2**	**4**	**2**

Section Five

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

Health and social care (HSC) complaints continue to be the most significant area of work for my office, accounting for 45% of the complaints received and some 80% of the workload. My jurisdiction in relation to health differs from my other jurisdictions in that I can examine the clinical judgments of health professionals without the need to first establish maladministration. From 1 April 2016, under the 2016 Act, my jurisdiction has similarly been extended to enable me to consider the merits of social care decisions.

HSC Complaints

The total number of new HSC complaints received in 2015-16 (332) is broadly similar to that reported in 2014-15 (337). There was a 1.5% reduction in this year. This is a small reduction in proportion to the overall reduction of 11% in the number of complaints across all jurisdictions received by my Office during 2015-16. Nevertheless the general trend in HSC complaints from 2009-10 to 2014-15 has been upwards, peaking at 370 in 2013-14. While it would appear that the upward trend has now been halted, because of the complexity of the issues, health complaints are less likely to be resolved quickly and at the end of 2015-16 they comprised 64% of all ongoing investigations.

The proportion of the total number of complaints received by my office which related to health and social care has again increased - from 38% in 2013-14 to 41% in 2014-15 and rising further to 45% in 2015-16.

New complaints in 2015-16 about HSC trusts account for 86% of HSC complaints received with the remaining 14% spread across a range of other HSC providers, including general practitioners who account for 7% of complaints and private nursing homes 3%.

During 2015-16 I issued 44 HSC reports covering 106 issues of complaint. I upheld 42 issues of complaint and 64 issues of complaint were either not upheld or I could not make a finding. I thus upheld 40% of the issues of complaint brought to me in this sector. Complainants will generally bring a number of issues of complaint to me for investigation and on average each investigation involves reporting on 3 issues of complaint. This is however after a process of initial assessment to allow my staff to concentrate my investigation on the significant and contested issues of the complaint which remain unresolved.

Delays in Responses from Bodies

In considering the health and social care complaints investigated by my office I have noted a number of issues of concern. As Ombudsman my office is an office of last resort and I will generally expect complainants to have exhausted the complaints process of the HSC provider prior to bringing their complaint to me. Given that organisations have been afforded the opportunity to investigate and respond to the concerns raised by the complainant, I find it difficult to understand the considerable delay which my investigators are experiencing in receiving responses to enquiries when complaints are accepted for investigation. The delays experienced add to the length of time that it takes to complete those already complex investigations and to the frustration of complainants. They have often been through extended local resolution with the HSC provider (I will comment on this further below). The issue of delay in responding to my enquiries is one which I intend to raise with health and social care providers.

Non compliance with Complaints Handling Guidelines

HSC Complaints are dealt with in accordance with guidelines issued by the legacy Department of Health Social Services and Public Safety *'Complaints in Health and Social Care; Standards and Guidelines for Resolution and Learning'.* The guidelines have proved to be a useful framework. However I am concerned that there is insufficient independence, rigour and constructive challenge in the internal complaints process of some HSC organisations. This delays the complaints process and leads to increased frustration and mistrust on the part of complainants, making complaints much more difficult to resolve. The principles of an effective complaints procedure as set out in the DHSSPS guidelines remain relevant and should form the basis of the approach taken by HSC providers. As I have identified above the local resolution of health complaints can continue for a prolonged period. I have no doubt the length of time taken by HSC providers in local resolution is driven by a desire to find a resolution. It is however taking too long to complete this process. There are also instances where I have identified considerable delays in local resolution which cannot be easily explained. Delays in local resolution add considerably to the frustration of complainants.

My experience of considering HSC complaints is that they should be seen as an opportunity to learn and that there is a genuine effort to both resolve complaints and to learn from them. Learning from complaints in HSC Trusts is a real challenge and as stated elsewhere in this report I intend to engage with this sector to secure improvements in the transmission of feedback from complaints to service areas, so as to increase learning opportunities.

As in previous years a number of the complaints that I have investigated involved more than one HSC provider. Where appropriate I continue to issue combined reports to ensure that the information provided to the complainant reflects their journey through the healthcare system and that the opportunities for learning are maximised across this sector.

In keeping with previous years the overriding issue of complaint made to me in relation to health and social care was failures in clinical care and treatment. HSC complaint handling was also a significant issue. In keeping with previous years the majority of HSC complaints warranting full investigation (56%) related to health and social care trusts but a significant number of investigations this year (26%) related to GP practices.

I noted last year that clear communication between those involved in patient care and the patient and/or their family is an important element in determining how individuals view the quality of care provided. Communication or more properly a lack of clear communication was raised as an issue in a number of complaints which I reported on in this year. The extent and level of communication with family members of a patient with incapacity or with mental health issues is a difficult issue for HSC providers. I would remind those involved in providing care of the need to communicate clearly and in a timely manner with patients and their families to the extent permitted. I would urge those involved to take the time to ensure understanding particularly when communicating key information in relation to diagnosis, prognosis, treatment or tests and ensuring the presence of family members where this would be beneficial.

Complaints Statistics

As stated above, in 2015-16 my Office received a total of 332 written complaints about Health and Social Care. This is just 5 fewer than the previous year. The breakdown of these complaints is provided below.

Written Complaints Received in 2015-16 by Authority Type

Authority Type	Number
Health & Social Care Trusts	285
Health & Social Care Board	4
General Practitioners	23
Private Nursing Homes	9
Regulation and Quality Improvement Authority	2
Other Health & Social Care Bodies	9
Total	**332**

Recommendations in Reported and Settled Cases 2014-15

Case No	Body	Recommendation
13312	South Eastern Health & Social Care Trust	Apology and Service Improvement
13651	Health Service Providers - GDP	Apology and Service Improvement
13691	Southern Health & Social Care Trust	Apology and Service Improvement
13703	Western Health & Social Care Trust	Apology and Service Improvement
13805	Health Service Providers - GP	Apology and Service Improvement
13863	Regional Health & Social Care Board	Apology
13971	Northern Health & Social Care Trust	Apology and Service Improvement
13991	Independent HSC Provider - Private Nursing Home	Apology
14068	Southern Health & Social Care Trust	Apology
14069	Northern Health & Social Care Trust	Service Improvement
14194	Belfast Health & Social Care Trust	Apology
14270	Health Service Providers - GDP	Apology and Service Improvement
14314	Western Health & Social Care Trust	Apology
14374	Northern Health & Social Care Trust	Apology and Service Improvement
14466	South Eastern Health & Social Care Trust	Apology and Service Improvement
14474	Health Service Providers - GP	Apology
14594	Independent HSC Provider - Out of Hours GP Services	Apology
14597	Southern Health & Social Care Trust	Apology and Service Improvement
14685	Western Health & Social Care Trust	Apology
14733	Health Service Providers - GP	Apology
15102	Western Health & Social Care Trust	Apology and Service Improvement
15215	South Eastern Health & Social Care Trust	Apology
15443	Independent HSC Provider	Apology and Service Improvement
15469	Health Service Providers - GP	Apology
15635	Western Health & Social Care Trust	Payment of £1,000

15665	Southern Health & Social Care Trust	Apology
15708	Health Service Providers - GP	Apology and Service Improvement
15863	Regional Health & Social Care Board	Apology and Service Improvement
15890	Regional Health & Social Care Board	Apology and Service Improvement
15997	Regional Health & Social Care Board	Service Improvement
16129	Western Health & Social Care Trust	Refund of fees to the amount of £1,162
16331	Belfast Health & Social Care Trust	Apology and Service Improvement

Analysis of Written Complaints Determined in 2015-16

	Brought Forward @ 1/4/15	Complaints Received in 2015-16	Determined at KPI* 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/16
Health & Social Care Trusts	70	285	202	65	26	62
Other Health & Social Services Bodies	19	47	29	8	18	11
Total	**89**	**332**	**231**	**73**	**44**	**73**

* For explanations of "KPIs" see Appendix C

Analysis of Written Complaints against Health & Social Care Trusts

	Brought Forward @ 1/4/15	Complaints Received in 2015-16	Determined at KPI* 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/16
Belfast Health & Social Care Trust	13	87	61	22	3	14
Northern Health & Social Care Trust	9	40	32	7	5	5
Northern Ireland Ambulance Service Trust	2	7	4	2	0	3
South Eastern Health & Social Care Trust	14	46	33	11	3	13
South Eastern Health & Social Care Trust (Prison Healthcare)	2	17	11	4	2	2
Southern Health & Social Care Trust	14	49	32	9	6	16
Western Health & Social Care Trust	16	39	29	10	7	9
Total	**70**	**285**	**202**	**65**	**26**	**62**

Analysis of Written Complaints against Other Health and Social Care Bodies

	Brought Forward @ 1/4/15	Complaints Received in 2015-16	Determined at KPI* 1	Determined at KPI 2	Determined at KPI 3	Carried Forward @ 31/3/16
Health Service Providers - GDP	2	0	0	0	2	0
Health Service Providers - GP	8	23	16	3	8	4
Independent HSC Provider	2	7	4	2	1	2
Independent HSC Provider - Out of Hours GP Services	1	0	0	0	1	0
Independent HSC Provider - Private Nursing Home	3	9	5	1	2	4
Not Specified HC Body	0	2	2	0	0	0
Health & Social Care Board	2	4	0	2	4	0
Regulation and Quality Improvement Authority	1	2	2	0	0	1
Total	**19**	**47**	**29**	**8**	**18**	**11**

Section Six

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

Section Six

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 2015-16 I received 33 complaints that councillors had breached the Code. These involved in total 22 councillors, fewer than 5% of the total of 460 councillors in Northern Ireland.

These 33 complaints represent a 136% increase on the 14 complaints received in 2014-15. The majority related to allegations that councillors had failed to meet their obligations as a councillor (23 instances) including the requirement to act lawfully and the requirement not to bring the position of councillor or the council into disrepute. The second most common basis of complaint related to allegations that a councillor had failed to show respect and consideration for others (18 instances). It is interesting to note that a significant number of these complaints resulted from councillors' use of social media.

Including complaints brought forward from 2014-15, 31 were closed down during the year. More than three quarters of these were closed down within 4 weeks (at initial assessment or assessment stage) because they didn't meet the criteria for investigation. Three investigations were concluded in 2015-16 (no investigations had been concluded during 2014-15). No adjudications have been held to date.

The legislation governing my role is contained in Part 9 of the Local Government Act (NI) 2014 (the 2014 Act). In determining whether a complaint should be investigated and in conducting my investigations, the key features of my approach are:

- **That the complainant must provide evidence** to support the allegation that there has been a breach of the Code, or identify where such evidence is readily available before a decision is taken to investigate a complaint. The requirement for supporting evidence ensures that vexatious, malicious or frivolous complaints will not be investigated.
- **That investigations are conducted in private**; the confidentiality of the investigation is a requirement of the 2014 Act. I consider it essential that confidentiality is maintained in order to protect the reputation of those complained of and the integrity of the investigation process.
- **That the investigation and adjudication process is fair and transparent**; this requires that councillors are made aware of the allegations against them at the outset. Fair process also requires that councillors or their representatives are afforded an opportunity, at each stage of the process, to make representations to my Office and to provide evidence in their own defence. For example, where it is likely that the outcome of an investigation is that I should adjudicate on the matter investigated, councillors have an opportunity to comment on the draft investigation report prior to the conclusion of the investigation and to have those comments considered before the report is finalised. At any adjudication hearing a councillor, or his or her representative, will have the right to ask questions of those giving evidence against them and to produce witnesses and documents to support their case.

- **That the investigation is completed within a reasonable period of time**. Timely completion of the investigation is dependent on a number of factors, including the complexity of the complaint; the availability and timely submission of relevant evidence, and the extent to which the councillor and other relevant witnesses co-operate with the investigation. I aim to complete the investigation of a complaint within 48 weeks of the date my Office notified the councillor, and the complainant, of the decision to conduct an investigation. In 2015-16 this key performance indicator (KPI) was met in 100% of complaints investigated (3 out of 3 cases). Despite this performance, I do not propose at this point to shorten the target timescales for completion of an investigation. In my view further consideration will be required before taking such a step given the relatively recent introduction of the Code (in May 2014) and the difficulty, at this early stage, in predicting the future volume of cases. I intend to continue to keep this KPI target under review.

DOE Review of the Code

In November 2015, the then Minister of the Environment, Mark H. Durkan MLA, appointed a working group to review Part 3 (Principles) and Part 8 (Decision Making) of the Code. This was in response to an undertaking provided to the Northern Ireland Assembly, in May 2014, to consider whether any changes should be made when the outcome of the ongoing review of the Code of Conduct of the Northern Ireland Assembly (the MLA Code) was known. A revised MLA Code was approved by the Assembly on 23 June 2015. In addition, the Departmental Review was to address concerns raised by councillors that the rules on decision-making were so restrictive that they did not allow councillors to behave fully as politicians or as public representatives.

I look forward to the outcome of the Departmental Review process and will contribute fully to any future consultation or discussion on any proposed revisions to the Code.

Public Interest Considerations

In regulating ethical standards in local government, my aim is to help councillors achieve the standard of conduct which meets public expectations; to support proper decision-making in local government and the proper use of public resources; and to maintain public confidence in local government. Undertaking investigations that do not support these wider benefits is not in the public interest. In addition, my resources are limited and it is important that I focus on the investigation of significant matters which are central to the relationship between councillors and the public they serve.

To assist my staff in their consideration of the public interest in deciding whether to undertake or to continue an investigation, I have provided Public Interest Considerations guidance. However Public Interest considerations are not the only criteria which must be met in deciding whether to investigate a complaint. It is essential, for instance, that the complaint is also supported by evidence of a breach of the Code. In determining whether an investigation (or adjudication) is in the public interest, my staff will consider the following factors:

- **Seriousness:** the more serious the alleged breach, the more likely it is that an investigation is required. When deciding the level of seriousness of the alleged breach, relevant factors are the extent to which the councillor was responsible for or was to blame for the breach; the circumstances of the complainant; and whether the alleged conduct caused harm to any person;

- **Proportionality:** the cost of an investigation, and any adjudication, is a relevant factor when making an overall assessment of the public interest, especially where these costs could be regarded as excessive when weighed against any likely sanction.

The Public Interest Considerations were published on my website in May 2015.

The Alternative Actions Policy

The 2014 Act provides for me to take action 'instead of', or 'in addition to', conducting an investigation, to deal with an alleged breach of the Code. I am committed to providing an alternative resolution of complaints where it is in the public interest to do so, in place of or in addition to an investigation. In November 2015, I launched a pubic consultation on 'Alternative Actions' proposals. The proposals set out the alternative resolutions I would consider applying and the circumstances in which their application may be appropriate. The consultation period ended on 15 January 2016. The Alternative Actions Policy has been published in June 2016.

The aim of my Alternative Action Policy is to bring about a satisfactory resolution of a complaint without the cost and resource implications of an investigation and/or adjudication. The Policy is also intended to encourage compliance with the Code of Conduct and to demonstrate my commitment to promoting ethical conduct as well as to deal with potential breaches of the Code in a proportionate and appropriate manner in all the circumstances of the case.

The Policy identifies six possible Alternative Actions and provides details of the circumstances in which each of the actions may be appropriate and how these actions would be implemented in practice. The action to be taken in any particular case will be at my discretion, having regard to all the circumstances of the case. Full details of my Alternative Actions Policy are available on my website at www.nipso.org.uk/nilgcs. In summary the Alternative Actions are:

- **Reminder of Obligations under the Code**
- **Apology to the Complainant or the Public at large**
- **Rectification**
- **Disclosure to another body**
- **Training on the Code**
- **Mediation**

Policy Development

In addition to publishing Public Interest Considerations and an Alternative Actions Policy as outlined above, I have also in 2015-16 developed Adjudication Procedures and Sanctions Guidelines. My staff liaised with the Office of the Information Commissioner in developing a Privacy Impact Assessment for local government ethical standards investigation and adjudication procedures. I intend to make these procedures publicly available by autumn 2016.

Engagement with Key Stakeholders

During 2015-16 my Office engaged widely with stakeholders to promote understanding of the Code and its requirements and to promote the lessons arising from the casework to date. I delivered a series of presentations to councils for Newry, Mourne and Down; Derry and Strabane; Fermanagh and Omagh; Lisburn and Castlereagh. In September 2015, I was welcomed as guest speaker at the Annual General Meeting of the National Association of Councillors Northern Ireland. I spoke to the Northern Ireland Local Government Association Members Meeting in September 2015. At the Local Government Reform Conference in Lisburn in February 2016, I was part of a distinguished panel addressing good governance in practice and the application of the Code.

My office has also engaged extensively with senior representatives from oversight bodies which have a regulatory role and with other regulatory bodies. These include the Local Government Auditor, the Electoral Commission, the Information Commissioner, the Pharmaceutical Society of Northern Ireland, the Office of the Irish Ombudsman, the Public Services Ombudsman for Wales, the Standards Commission for Scotland, and the Commissioner for Ethical Standards in Public Life in Scotland. My Office has continued to benefit from a productive working relationship with DOE officials in matters relating to ethical standards.

In my 2014-15 Annual Report, I stated my intention to compile Memoranda of Understanding with other regulatory bodies whose remit includes local government matters. In September 2015 I signed the first such memorandum with the Comptroller and Auditor General and the Local Government Auditor.

The Introduction of the role of Northern Ireland Local Government Commissioner for Standards

In addition to creating the office of Northern Ireland Public Services Ombudsman the 2016 Act provides for me to exercise functions under the 2014 Act as the Northern Ireland Local Government Commissioner for Standards (NILGCS). In preparing for this change, my Office has worked closely with DOE.

My Office has also reviewed, updated and rebranded forms and guidance leaflets to reflect the new function; provided up-to-date guidance for councillors and complainants and developed a stand-alone section of the NIPSO website (www.nipso.org.uk/nilgsc) providing detailed information and guidance on the NILGCS function to both complainants and councillors.

Statistical Information – Local Government Ethical Standards

Caseload

	2015/16	2014/15
Enquiries (not resulting in a Complaint)	8	4
Complaints ongoing from previous year (a)	9	N/A
Written Complaints Received in year (b)	33	14
Total complaints under investigation in year [(a) + (b)]	**42**	**14**
Number closed at Initial Assessment Stage "can we investigate?"	12	3
Number closed at Assessment Stage "should we investigate?"	16	2
Number determined at Investigation Stage	3	0
Number of Complaints Withdrawn	1	0
Number of Complaints Ongoing at year end	**10**	**9**

Basis of Complaint*

	2015/16	2014/15
Obligations as a Councillor	23	13
Behaviour towards other people	18	10
Use of Position	2	1
Disclosure of Information	1	3
Decision-making	0	3
Use of Council Resources	5	0
Total	**49**	**30**

* Relates to valid complaints only. A number of complaints refer to more than one alleged breach.

Written Complaints Received by Council

	2015/16	2014/15
Antrim and Newtownabbey	2	2
Mid and East Antrim	2	3
Armagh, Banbridge and Craigavon	1	4
Belfast	4	1
Causeway Coast and Glens	6	0
Derry and Strabane	6	2
Fermanagh and Omagh	2	0
Mid Ulster	3	0
Newry, Mourne and Down	4	2
North Down and Ards	2	0
Lisburn and Castlereagh	1	0
Total	**33**	**14**

Appendix A
Principles of Good Administration

Appendix A

Principles of Good Administration

[Source: Parliamentary and Health Service Ombudsman]

Good administration by public bodies means:

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

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

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

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

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

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

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 Education

Remuneration Dispute

In this case, Mr Stephen Moutray MLA sponsored a complaint to me about the actions of the Department of Education. The complaint concerns the Department's handling of three recommendations that the complainant's (now former) employer, the Southern Education and Library Board (SELB) made to the Department for payment of additional pay for work undertaken by the complainant.

The complaint was that the Department delayed unnecessarily in progressing the payment recommendations that the SELB put to it; that it failed to provide appropriate advice and guidance to the SELB to enable it to submit the required information in the appropriate format; that it failed to provide timely responses (or a response at all) to correspondence from the complainant; that it failed to meet undertakings to provide the complainant with information within specified timescales; and that it failed to provide appropriate responses to two letters the complainant had sent to the Minister for Education in July 2012 and January 2013 respectively.

My investigation found a number of instances of maladministration and that action, and inaction, by the Department led to periods of avoidable delay in the consideration of the three payment recommendations made by the SELB; that the Department failed to provide timely and appropriate responses to the complainant's letters to the Minister; that the Department did not meet undertakings given to provide information; and that it failed to provide any responses to some of the complainant's correspondence. However, I found no evidence that the Department failed to provide appropriate advice and guidance to the SELB in relation to the payment recommendations.

I was satisfied that the maladministration I found caused the complainant to suffer the injustice of frustration and disappointment, and of being put to an unreasonable degree of time and trouble to obtain information from the Department. I was also satisfied that the Department's actions contributed to the unacceptable delay in payments to the complainant, and the pension and redundancy payment adjustments she received post retirement.

I recommended that the Department's Permanent Secretary provide a written apology, and a payment of £750. I am pleased to record that this recommendation was accepted by the Department.

Department of Enterprise Trade and investment

Surrender of Life Insurance Policy

Sponsored by Michael Copeland MLA, I received a complaint about the Department of Enterprise, Trade and Investment (DETI). The complainants stated that the actions of DETI in surrendering their critical illness and life insurance policy following bankruptcy were needless and unreasonable, despite previous communications disclosing health concerns of the husband. Sadly the husband passed away prior to the completion of the investigation. However, I continued with the investigation in his wife's name.

In considering the complaint, I sought to establish whether DETI had caused an injustice to the complainant as a result of maladministration. I found failures in the standard of service which the complainant received from DETI. Taken together, I considered these failings to represent maladministration. The complainant suffered the injustice of uncertainty and confusion and had to pursue the DETI for clarity in the matter of buying out her interest in the policy following her bankruptcy. I also found maladministration in the failure of the DETI to signpost the complainant to the next level of the complaints process. As a result the complainant suffered the injustice of confusion and uncertainty with how to proceed with her complaint. I recommended that DETI apologised to the complainant and offered financial redress of £500 for the maladministration. I also recommended that DETI complete the formalisation of written procedures on the realisation of life policies.

However, from my careful examination of the evidence I noted that the surrender of the complainant's life insurance policy was in line with established practice and ultimately the complainant was provided with sufficient information about the process. In the circumstances I had no reason to challenge DETI's decision in surrendering the policy and realising the interest.

Department of Justice – Northern Ireland Prison Service

Failure to adhere to Policy and Procedure

In this complaint, brought to me by Peter Weir MLA, the complainant was an employee of the Northern Ireland Prison Service (NIPS) when a Voluntary Early Retirement Scheme (VERS) was introduced. In November 2011 NIPS issued a notice to staff which set out the terms and timescale for the VERS. Staff were advised that if they applied for the scheme and were selected, they were committed to leaving. In March 2012 the complainant received confirmation from NIPS that he had been selected and he would be permitted to leave at the end of the month. NIPS also confirmed that it would pay his Compensation in Lieu of Notice (CILON) and Additional Payment at the end of April 2012. A subsequent letter from NIPS advised that these payments would instead be made on 31 March 2012.

The complainant was concerned that the decision to change the payment date of the VERS Payments from April 2012 to March 2012 meant that he suffered a financial loss as the timing meant that he paid a larger amount at the 40% tax rate (within the tax year 2011-12). Also he was unhappy that he was not afforded the opportunity to withdraw his application once the terms were changed (i.e. the payment date changed from April 2012 to March 2012). He complained to NIPS but remained unhappy with its response.

I examined the NIPS information and the relevant HMRC regulations and was satisfied that the complainant suffered no financial loss. That is because he accepted the terms of the VERS which stated that he would leave on 31 March 2012. At that date, he became entitled to the VERS payments and paid tax accordingly. I was also satisfied that the change in payment date from April 2012 to March 2012 did not justify withdrawal from the scheme as there was no maladministration evident in NIPS decision regarding the altered date of payment.

However I identified areas of maladministration in NIPS' failure to provide clear and accurate information within its selection documentation to staff, which caused the complainant to mistakenly believe that he would pay tax on his VERS payments in the 2012-13 tax year. I found also that NIPS failed to record key information provided during staff meetings in relation to VERS and in particular communications with staff when it was identified by NIPS that some staff remained unclear in their understanding of the tax implications of leaving in March 2012. This was further compounded by the complainant not receiving all VERS documentation because he was on sick leave. I identified that NIPS failed to have in place a 'Keeping in touch' policy in order to provide appropriate guidance on the correspondence and recording of information sent to those on sick leave. Finally I found that NIPS failed to properly consider their legal advice concerning withdrawal from the scheme. To remedy the injustice of upset, frustration and inconvenience sustained by the complainant, I recommended that NIPS:

- Ensure that any documentation provided to staff in relation to future schemes is clear, accurate and complete.
- Implement a 'Keeping in Touch' policy which covers the distribution of relevant organisational developments and opportunities to members of staff on leave or absent due to illness and that a record is made of any such correspondence.
- Record minutes of significant staff meetings.
- Offer the complainant an apology and a payment of £350.

I am pleased to record that NIPS accepted these recommendations.

Department of the Environment – Driver and Vehicle Agency

Misleading Penalty Notice Enforcement Advice

In this case, brought to me by Michelle McIlveen MLA, the complainant was one of two drivers of wedding cars when they were approached by Driver and Vehicle Agency (DVA) staff. It was established that neither vehicle had an appropriate PSV licence. A Fixed Penalty Notice (FPN) with a £30 fine was issued to each driver. In addition both drivers received a FPN and £60 fine for driving without a PSV licence - an endorsable penalty which also carried 3 penalty points. The DVA Enforcement Officer then explained that the complainant could either accept the £60 fine and 3 penalty points or go to court and challenge the charges against him. The complainant elected to accept the FPN and £60 fine and submitted his licence to have the penalty points applied. The second driver indicated that he would not pay the fine and was prepared to challenge the FPN in court; which he did and he did not receive his penalty points; neither was he summoned or prosecuted.

The specific issues of complaints were:

1. The complainant was not made aware that the decision to prosecute would be taken initially by a DVA Enforcement Manager and subsequently by the PPS and he was informed that going to court was the only alternative to payment of the fine and accepting 3 penalty points.
2. The FPN was misleading and did not detail the element of discretion as to whether or not the case would go to Court.

I found maladministration in that the wording on the FPN was misleading. The investigation also found as a consequence of this maladministration, that the complainant experienced the injustice of not being afforded the opportunity of making an informed decision on whether to request a court hearing. I recommended that the DVA Chief Executive issue a letter of apology to the complainant and that a payment of £50 should be made as redress for the time and inconvenience involved for him in pursuing his complaint.

I also recommended that the DVA should give consideration to reviewing the wording of the FPN and also initiate a review of any oral information provided to individuals by DVA Enforcement Officers, with a view to ensuring that the information provided is accurate, clear and that it is not misleading.

I was pleased to note the positive engagement with my office and DVA's response to my report and its commitment to promptly implement the recommendations.

Northern Ireland Commissioner for Complaints – Selected Investigation Summaries

Armagh, Banbridge & Craigavon Borough Council

Poor Complaint Handling

This case concerned the Council's handling of a complaint submitted in January 2012 regarding the actions of a local government officer. The complainant was unhappy about the Council's failure to investigate his complaint appropriately and also the significant delay in providing a response.

The complainant initially raised his complaint to the Council about the actions of a Council employee in relation to matters involving a registered charity with which they were both involved. He complained that the Council employee was sending emails from his Council email address to members of the charity and that these were inappropriate in that they aimed to influence the governance of the charity.

After engaging in the Council's complaints process for a significant period, the complainant submitted his complaint to my Office. Although he had not exhausted the Council's complaints procedure, I exercised my discretion and

accepted the complaint, given the length of time which had elapsed without the Council reaching a conclusion. However, it is important to note that whilst I accepted the complaint for investigation, from the outset the complainant was advised that the focus of my investigation would be the Council's handling of his complaint and not the substance of the allegations made against the Council employee.

I found maladministration by the Council in terms of the poor handling of the complaint, which included a delay in responding for more than 38 months, a failure to provide updates on any progress on the complaint and the failure to respond to numerous requests for information.

I recommended that the Chief Executive (CE) provide an apology in light of the failings that I identified during my complaint investigation. I am pleased to note the CE responded positively to my investigation and that the recommendations have been implemented.

Inadequate Complaint Handling

The complainant in this case, an employee of the legacy Craigavon Borough Council (The Council), complained that the Council failed to accept and investigate three of his grievances which he had lodged in August 2013 and March 2014. The first related to the Council's failure to process his previous grievances, as well as a grievance lodged against him by another employee of the Council. This grievance was rejected by the Council on the basis that they considered it an unreasonable use of the grievance process to attempt to revisit these matters under a fresh grievance. The second related to a grievance the complainant had lodged against senior Council staff alleging bullying and harassment. This was rejected on the basis that the complainant refused to provide details of these allegations when requested by the Council's HR department. The third grievance related to the Council's failure to process the two previous grievances and was rejected by the Council on the basis that it was 'not brought in good faith' and was 'spurious' as stated in the Council's Grievance Policy.

I arranged for enquiries to be made of the Chief Executive (CE) of the Council who provided me with copies of the complainant's previous grievances and the relevant Council policies. The CE informed me that the complainant had lodged the first grievance in August 2013. However he did not withdraw two of his previous grievances against two Council employees until 13 and 16 August 2013 respectively. As the handling of these grievances was the subject of the first grievance, the Council had already committed significant resources to resolving his previous grievances and were not prepared to process a fresh grievance about these matters. In relation to the second grievance, the complainant was asked to provide a brief explanation of the basis of his complaint as is required under their policies but the complainant refused to do so. In relation to the third grievance, the Council referred to the considerable amount of time and financial resources it had committed in addressing the complainant's grievances with little progress having been made and the fact that the grievances were continually being raised by the complainant.

I found maladministration by the Council for refusing the first and third grievances as this decision was contrary to its own policy and Labour Relations Agency (LRA) guidance which does not give the employer the discretion to refuse to accept grievances without first meeting with the employee. I also found

maladministration with respect to the Council's Grievance Policy which is not clear on how it is to be determined that a grievance is considered spurious, who makes that decision and the consequences of such a determination. I also found maladministration in the Council's communication with the complainant following receipt of the third grievance.

Notably, I did not find maladministration in the aspects of the complaint relating to the second grievance as I found that the complainant ought to have provided details of his grievance to allow it to be progressed. However I did comment on the lack of clarity of some grievance policies.

I consider it important to record that while complainants have a right to complain they also have a responsibility to provide full information.

I also commented on the impact of the complainant's actions on the Council's response to his grievances. I considered his actions were not helpful in failing to provide full details of his grievances which contained serious allegations and subsequently withdrawing his original grievances. I also recognise the impact his various grievances had on the Council's resources and that the Council CE had already apologised to the complainant for previous failings in dealing with his grievances.

I considered that the complainant was caused the injustice of lost opportunity to have the first two grievances dealt with appropriately and in accordance with the Council's own policy and the relevant LRA guidance. In this instance I did not consider it appropriate to recommend that the Council affords the complainant the opportunity to re-open Grievance 1. I therefore urged the complainant to reflect on my conclusions and recommendations and for him and the Council to take the opportunity presented by the formation of a new Council to move forward and establish a more positive employer/employee relationship. I also made the following recommendations:

- that the Council CE should personally provide an apology to the complainant for these failings and that the Council make a commitment to move towards a more positive working relationship with the complainant;
- that the Council provide appropriate training to HR staff including a clear statement of policy that no grievance can be rejected or not accepted until the Council has provided an opportunity for the employee to discuss the grievance with the appropriate Council staff;
- that the Council takes the opportunity to ensure the new Council's HR policies are amended to reflect the lessons learned from this investigation.

I am pleased to state that the Council has accepted these recommendations in full.

Arts Council for Northern Ireland

Failure in policy and procedures

The complainant unsuccessfully applied to the Arts Council NI for the Individual Artist's Programme. Her application failed on the ground of 'artistic quality'. She was advised, as part of feedback that her application was not in a suitable style. A review was carried out by the Chief Executive at her request. The review included reference to the complainant's failure to provide 'letters of invitation to exhibit' which the Arts Council staff had indicated were unnecessary.

The complainant complained about the lack of adequate reasons for the decision. She alleged that the assessing officer lacked impartiality and had dissuaded her from re-applying.

I found lack of clarity in the Arts Councils Individual Arts Award application form and guidelines. I therefore recommended that this was clarified in future applications. However I found the impact of these 'letters of invitation' on the final funding decision in the complainant's individual case to be negligible.

I was satisfied that the assessing officer correctly scored the complainant's application according to Arts Council criteria and that a different assessing officer would not have resulted in a different outcome. I urged the complainant to engage with the Arts Council in a constructive way so that their feedback could assist her with future funding applications. I am pleased to note the Arts Council accepted my recommendations.

Education Authority

Handling of Bullying and Related Issues

The complainant in this case had initially complained to Mr John O'Dowd, MLA, Education Minister in July 2012. The complaint related to bullying against her daughter whilst a pupil of Lack Primary School, the failure of the Board of Governors (the Board) to effectively manage the school, the prioritising of work for transfer tests to the detriment of ordinary school work and the rudeness of a teacher towards the complainant.

My investigation found that the Investigation Panel, acting on behalf of the Board, failed to carry out a thorough investigation in relation to the allegation of bullying for the following reasons:

- the failure to have clear terms of reference for the investigation;
- the decision to restrict the period under investigation from November 2011 to May 2012;
- the failure to interview important witnesses;
- the failure to address the issue of bias by teaching staff.

I considered these failings to constitute maladministration. I was satisfied that as a consequence of this maladministration the complainant suffered the injustice of not being afforded a thorough investigation of her complaint. Therefore I upheld this element of the complaint.

I recommended that the Chief Executive of the Education Authority issue a letter of apology for the Board's failure to provide the complainant with a thorough investigation into her complaint of bullying. I also recommended that the Education Authority should consider undertaking a review of its complaints procedures, which I am pleased to note they have now completed.

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

Belfast Health and Social Care Trust

Mental Health Care and Treatment

The Trust's care and treatment of the complainant's late brother was the subject of a complaint to my office. The patient had taken a fatal overdose of his prescribed medication on 4 September 2011. The complainant complained to me as she was dissatisfied with the Trust's response to her complaint.

This was a tragic and distressing case which involved the sudden and unexpected death of a young man following an overdose of prescribed anti-psychotic medication. It is evident that he was a much loved son and brother and that his family provided a high level of support to him in dealing with his mental health problems. He had alerted his mother to the fact that he had taken an overdose on the evening in question and she immediately brought him to the Hospital Emergency Department (ED). The grief of the family at his sudden death was compounded by the fact that he was in the care of the ED when he died; and they expected he would receive treatment for the effects of the overdose. The family were also concerned that no indication was provided by the ED staff that the overdose was potentially fatal.

Given the circumstances of his death, the family were left with questions about whether his death was avoidable. It became evident however from my investigation that this death was also a shock to the ED staff as there was no available information from the specialist poisons information service that the overdose was potentially fatal. I found failings in some aspects of the care and treatment provided and the way in which the family's complaint and the Serious Adverse Incident (SAI) process were handled. However, I found that the deceased was treated in accordance with the specialist advice available at the time and there was nothing that the staff could have done to treat him given the type of medication he had taken.

I also found that the Community Psychiatric Nurse (CPN) failed to provide appropriate follow-up treatment when the deceased's mother rang the Trust's Clozapine Clinic (Clinic for Psychiatric Outpatients and Adult Mental Health) on 1 September 2011 to inform them of a decline in her son's mental health. I also found that the Trust staff failed to carry out hourly observations on the deceased for two hours while he remained in the ED. This led to clinicians not being kept fully informed of his condition and the missed opportunity to re-assess and review his condition and to consider appropriate treatment.

Of particular concern in this case was the lack of appropriate care and assistance provided by the CPN after having been informed by the deceased's mother that his mental health had declined. Although I was unable to determine whether the outcome would have been any different if appropriate care had been provided, this case does underline the need for proper and thorough risk assessments to be carried out each time a patient's mental health is reported to have altered. I recommended to the Trust that the Clozapine Clinic nursing staff are fully trained and aware of the requirement for risk assessments to be conducted.

Also of concern in this case is the poor complaints handling and the delay in responding to the family's complaint. Whilst this did not have an impact on the care and treatment or indeed my investigation of the complaint, it did emphasise the need for the Trust to address delays in responding to complaints, particularly where responses are required from various sources. In terms of the complaints and SAI processes, I reminded the Trust of the importance of the need for better clarity and understanding on Trust processes both for patients and their families.

I recommended that the Trust's Chief Executive apologise to the complainant and her family. I also recommended that the Trust ensures that there is a clearer understanding of the SAI and complaints processes for families and patients in the future.

I did not uphold all elements of this complaint and I recognise this tragic outcome was very distressing for the complainant and her family. I welcome the efforts the Trust has made to meet future emergency care standards. I commend the Trust for their pro-active response in informing the NPIS (National Poison Information Service) of this tragedy so as to ensure the NPIS database could be updated and also for the supervision sessions on the database held with staff after this tragic event.

Northern Health & Social Care Trust

Failures in clinical care and record-keeping

I received a complaint relating to the standard of care and treatment provided to the complainant's late mother by the Northern Health and Social Care Trust (The Trust). The complaint related to the quality of home nursing care provided by the Trust in relation to the treatment of her mother's leg ulcers and pressure sores; the provision and use of suitable medical equipment (a hoist); and communication between the District Nurses and the patient's General Practitioner (GP).

I found maladministration in records management, with evidence of poor record keeping in relation to the recording of the treatment of both the patient's pressure sores and her ulcerated legs. These failings were not of themselves indicative of poor care and treatment. However, the complainant had to pursue her concerns without the investigation of her complaint being based on accurate, reliable and complete records which I considered to be an injustice.

In relation to the Trust's provision of a hoist, the Trust did not intend that it could or should be used by family members. I concluded that the provision of the hoist to transfer the patient from her bed was unduly delayed. This caused the patient to be confined to her bed as her carers had no other means by which they could transfer her to her recliner chair. I found this delay to be maladministration.

However, I concluded that the level of communication between the district nurses and the deceased's GP was adequate and appropriate and found no maladministration in that regard.

In relation to the maladministration that I did identify, I recommended a review of the Trust's 'Moving and Handling Risk Assessment Policy', and also a review of the procedure for the reordering of dressings used by District Nurses. I also recommended that the Trust reminds its staff of its Records Management Guidelines (June 2008) and also emphasises to staff the need for accurate, timely and complete record keeping consistent with Nursing and Midwifery Council (NMC) guidance.

I also recommended that the Trust acknowledge in writing to the complainant its commitment to review procedures and apologised for the distress and upset caused.

The Trust issued its apology to the complainant in January 2015. In accepting this apology the complainant expressed her appreciation of the effort in investigating her complaint and stated that she felt *'happier that lessons have been learnt from this and improvements implemented to help others and their families'.*

Failure to consider appropriate needs-based care package

The complainant in this case complained that his views in relation to his mother's care needs were not fully considered by the Northern Health and Social Care Trust (the Trust) at a meeting in May 2013 when determining her future care provision. At this meeting he alleged that he was not given the option of residential or nursing care for his mother as she was discharged to semi-independent living. He complained that as a result of this decision, she fell only two days after her discharge and lay on the floor for 8 ½ hours before she received attention.

Having obtained Independent Social Work Advice (ISWA), I found that the decision-making process was attended by significant maladministration. The extent of the maladministration underpinning the decision led me to the conclusion that the decision to place the complainant's mother in supported living accommodation was flawed and wrongly made. As a consequence of these failures, the complainant was not given the option of a residential setting for his mother. She experienced the injustice of being inappropriately placed in a fold setting. I have also found recurrent failures regarding the Trust's record keeping.

I recommended that the Trust issue a sincere written apology to the complainant and his mother. I made a number of other detailed recommendations in relation to service improvements and I am pleased to state these have been accepted by the Trust. In addition, the Trust informed me that a number of other actions have been identified that I am assured will safeguard future practice.

Southern Health & Social Care Trust

Autism Service

In 2013 I received a complaint about the Southern Health & Social Care Trust.

The complaint was about the diagnoses and treatment the complainant received whilst under the care of two consultant psychiatrists over an eight year period. The complaint also contained allegations of administrative errors and inappropriate correspondence from the Trust. The outcome the complainant was seeking was a referral to an appropriate professional with regard to Autistic Spectrum Disorder.

I was satisfied that the medication administered to the patient was appropriate to treat the presenting symptoms and that the drugs regime was reviewed and modified regularly based on efficacy and side effects and with consideration given to the patient's personal preferences. I found no evidence that medication was provided unnecessarily or that the care and treatment otherwise provided by the consultant psychiatrists was unsatisfactory. I did not, therefore, make a finding of maladministration in relation to diagnosis or treatment.

I found that the Trust's failure to provide any form of multidisciplinary Adult Autistic Spectrum Disorder assessment for the complainant following discharge from psychiatric services in 2012 amounted to maladministration. I upheld this element of the complaint and recommended that the Trust issues an apology to the complainant for causing the injustice of continuing uncertainty and worry about diagnosis and treatment.

I was pleased to note that an Adult Autistic Spectrum Disorder Assessment Service has been operational since September 2015. I recommended that the Trust offers a place to the complainant and furthermore, that it reviews how it might continue to adequately resource this important service in the future.

Care and treatment failures

I received a complaint from family members about the care and treatment provided to their late father by the Southern Health and Social Care Trust (the Trust). Their father was admitted to hospital in December 2012 with a recent history of respiratory infection. He was treated for pneumonia and an underlying heart condition but failed to respond to treatment and died the following day.

I concluded that overall the clinical care provided to their father was reasonable but that there were some areas where the care provided did not meet the required good practice standards.

The family was clear in their complaint that their priority in taking their father to hospital was to alleviate his pain and discomfort. I determined that the Trust failed to monitor the effectiveness of the pain relief administered to their father, or to properly implement the pressure sore prevention pathway. My finding was that this amounted to maladministration which caused the injustice of anxiety and distress to the complainants. I therefore upheld this element of the complaint.

I also found maladministration in relation to the failure of the Medical team to complete the Do Not Attempt Resuscitation (DNAR) Order form. However I did not consider that this failing resulted in an injustice to the family or to their father

as the decision not to resuscitate was based on sound clinical judgment and was adequately explained to the family and to their father. Whilst I did not uphold this element of the complaint, I recommended that the Trust reviews its 'Do Not Attempt Cardiopulmonary Resuscitation Policy' and ensures that DNAR Order forms are fully completed at the time the decision is made so that the rationale for the decision is clearly documented along with those fields in the form indicating that the patient and/or family has been informed.

I proposed by way of remedy that The Trust's Chief Executive Officer provides the family with a written apology in respect of the failures I identified. I also recommended that the Trust provides reassurance to the family by detailing what action has been taken to implement improvements, and to provide an assurance that their effectiveness will be monitored.

Hospital admission/discharge issues

The complainant in this case made a complaint to the South Eastern Health & Social Care Trust (SEHSCT) in relation to the care and treatment her mother received prior to her death.

The first of three elements to the complaint was the complainant's belief that her mother was seriously ill at the time of an out of hours consultation and should have been admitted to hospital. Having considered the overall circumstances of this element of the complaint and having taken into account the documentary evidence and the advice of my Independent Professional Advisor (IPA), I did not uphold this aspect of the complaint. I was satisfied that the complainant's mother's clinical presentation, while no doubt concerning to her family, did not warrant immediate hospital admittance.

The second element of the complaint related to the complainant's mother's discharge from the Ulster Hospital following admittance after a fall at home. The complaint was that the underlying seriousness of her mother's condition was not investigated or detected at this time. I found that the complainant's mother was deemed fit for discharge due to her stable clinical presentation. However I criticised the Trust for a failure to give sufficient weight to the patient's history. I considered that further investigations should have been made into her condition so that a fully informed decision could be made on hospital admission. I considered this failure to constitute maladministration.

The final element of the complaint concerned the appropriateness of the Trust's clinical decisions leading up to a diagnosis of lymphoma and whether this diagnosis could and should have been made earlier. In this case the time taken to reach a diagnosis was 21 days. After taking the advice of my IPA, I found that the time taken to diagnose was both timely and reasonable. I did not uphold this element of the complaint. I also considered that the standard of communication with the family and patient was not unreasonable during this period.

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

Mental Health Services (Complaint not upheld)

The complaint in this case concerned the actions of Southern Health and Social Care Trust (the Trust), and in particular Mental Health Services. The complainant alleged that the Consultant Psychiatrist, and the Community Psychiatric Nurse (CPN), both of whom had responsibility for the complainants care, failed to monitor and/or recognise the negative impact changes in his medication had on his mental and physical condition on a number of occasions. The complainant was also concerned that the CPN failed to inform the Consultant Psychiatrist that he [the complainant] had expressed thoughts of self harm and suicide.

Having completed a detailed investigation of this complaint, I determined that the care afforded to the complainant was professionally appropriate and in line with established practice. Whilst I expressed criticism of the Trust for not completing a care plan following discharge from hospital, I was satisfied that the complainant's ongoing condition was monitored by the CPN through regular home contact following discharge from inpatient care.

Western Health & Social Care Trust

Eating disorder treatment

This complaint was about the care and treatment provided by the Western Health and Social Care Trust (the Trust) to the complainant's daughter, who was suffering from anorexia nervosa. In particular the complaint alleged that the care and treatment provided failed to meet the relevant standards as set out in the relevant clinical guideline; there were inadequate written care plans; the daughter's signature was forged on a care plan; a variety of treatment modalities were not offered or made available; the review carried out on care and treatment was inaccurate; and the Trust failed to offer or provide the complainant and his family with support or therapy during the period that the Trust was responsible for providing the daughter's care and treatment.

Whilst I found that the overall care and treatment provided by the Trust was reasonable and the Trust had adhered to its *Care Pathway for Eating Disorders for patients of 16+* which does meet the standards set by the 2004 National Institute for Clinical Excellence (NICE) guidelines, I concluded that the Trust failed to provide appropriate family based therapy. I further concluded that this failure constituted maladministration. As a consequence, the acknowledged benefits of family based therapy were not available to the family at the time they were dealing with their daughter's illness. Moreover, I acknowledged that had such therapy been available to the family, it may have also positively impacted on the daughter's recovery. It may also have been beneficial in supporting all members of the family in dealing with the daughter's illness.

I recommended that the Trust ensure that appropriate family based therapy is offered and promoted to those families whose members are being treated following a diagnosis of anorexia nervosa and that family therapy is an integral part of the Trust's Care Pathway for Eating Disorders in all future cases. I also recommend that individual written care plans are discussed, agreed and implemented for patients, as early as possible after referral to the Eating Disorder Service (EDS).

Transition from Child to Adult Services (Complaint not upheld)

I received a complaint in which a parent claimed to have sustained injustice as a result of maladministration by the Western Health and Social Care Trust (the Trust).

The complainant's daughter had been severely mentally and physically handicapped from birth. She is a wheelchair user and was severely impaired in relation to speech, communication and understanding. She requires total support in all areas of personal hygiene and also suffered from asthma and eczema.

The main focus of the complaint related to changes in circumstances that arose and developed during the transfer of responsibility for, and content of, the care package upon transition from Children's Services to Adult Services at age 18.

The areas of complaint which I considered were an alleged failure to deliver an assessment in a timely manner, a claim that an increase in hours to the care package was inadequate, delay, lack of communication and a reduction in respite care.

In my consideration of the various elements of this complaint I did not find maladministration in the areas complained of. In concluding my report I expressed my hope that a more positive and trusting working relationship could be nurtured and developed in the future between Trust staff and the complainant. This would be to the benefit of the care recipient so that the most effective and appropriate support could be delivered to her and her family in the future.

Provision for suitable decant accommodation

I received a complaint that the Western Health and Social Care Trust (the Trust) failed in its duty to provide the complainant with suitable accommodation whilst her home was uninhabitable during adaptation work being carried out via a Disabled Facilities Grant. Being unaware of the Trust's duty in such cases, the complainant made a private arrangement to rent a property for the decant period and as a result she incurred a debt of £1,000.

During my examination of this complaint, it was clear that the Trust had been aware that the adaptation works to this property were imminent. Therefore, I considered that the Trust failed to make explicit that it has a responsibility to support or make payments to clients who require decanting for adaptation works.

More generally, as this is a statutory responsibility of the Trust, I believe that the onus is on the Trust to make its clients aware that such a provision exists and that suitable support may be available to them. I do not consider that the responsibility to request such support lies with the Trust's clients in circumstances where the Trust has failed to inform the client that a request for such support can be made to the Trust

I considered that the failure by the Trust to inform the complainant of the Trust's responsibilities to provide suitable support led her to incur a loss of £1,000. Rather than commence a potentially lengthy investigation and in accordance with my legislative requirement to effect an settlement of a complaint, where I consider it is both possible and desirable, I put forward a settlement proposal that the Trust make a payment of £1000 to the complainant to reimburse her for the financial loss which she incurred. I am pleased to say that the Trust, having reviewed this case, agreed to make an ex-gratia payment of £1,000.

In addition, I welcomed the Trust's acknowledgement that learning has been gained from this case to ensure that, in future, the advice given during any discussions with clients regarding major adaptations will be formally recorded in the client's record. I am satisfied that these service improvements will be of benefit to the wider public. I also sought reassurance from the Trust that sufficient work is ongoing to ensure that other people in similar situations are being properly informed of the Trust's responsibilities in circumstances where decanting may be an option and are being appropriately signposted by the Trust on all occasions.

Unsatisfactory discharge arrangements

I received a complaint regarding difficulties that the complainant experienced with her mother's care package.

The mother was admitted to Altnagelvin Hospital, and later South West Acute Hospital, with a fractured neck of femur. As the agreed care package had not been put in place on discharge, she was temporarily placed in a Nursing Home for two weeks.

The complainant alleged that there was no evidence that sufficient time and attention were given to organising the care package, and that even a partial care package would have made it possible to avoid the transfer of her mother to a nursing home. The complainant also stated that staff did not clearly explain to her the relevant Trust policies, or the various options available to her mother on discharge. Also, she stated that she was informed that payment for the two week stay in the nursing home was her family's responsibility, and that she had no choice but to pay and make a complaint later.

As part of the complaint assessment process I wrote to the Trust to ask it to comment on the complainant's issues of complaint. I also asked the Trust whether it would propose to make a settlement in this case.

I am pleased to note that the Trust offered a refund of £1,162 for the two weeks spent in the Nursing Home. I considered this to be a fair and satisfactory settlement of this matter, and wrote to the complainant informing her that this Office would be taking no further action in respect of this case.

Health and Social Care Board

Handling of Complaint about GP

The complainant in this case had attended her GP from 2010 to 2013 with syncopal episodes and occasional associated incontinence. The complainant described the GP's approach to her care and treatment during this period as 'lacklustre' and specifically that he failed to refer her for further tests in a timely fashion. The patient and GP relationship deteriorated and the complainant moved to a different GP practice in early 2013.

In May 2014 the complainant's husband complained to the Health and Social Care Board (the Board), who forwarded the complaint to the GP. The GP's response was forwarded to the complainant by the Board in June 2014.

The complainant's husband contacted the Board again in July 2014 stating his dissatisfaction with the response. The Board again contacted the GP who provided a further, more detailed, response in August 2014.

The complainant's husband remained unhappy with the further response from the GP and he requested to meet with the Board. This meeting took place in early September 2014 and the option of obtaining an independent medical report was discussed and agreed. The Board subsequently met with the GP Practice who agreed to an independent medical report being obtained.

The Board arranged for the complaint to be considered by two independent GPs. Their report found that the GP acted reasonably and in line with good medical practice. There was no evidence identified that would indicate a diagnosis was missed whilst the complainant was a patient of the GP. This report was issued by the Board to both the complainant and the GP in January 2015 and the complainant's view was that the independent medical report was indecisive and contradictory.

When this complaint was subsequently brought to me I considered whether the Board properly complied with established Health and Social Care complaints procedures when acting in their role as 'honest broker' regarding the complaint against the GP.

My investigation found that the Board failed to maintain accurate records of its meeting with the complainant's husband, that the Board took on the roles and responsibilities assigned to the GP Practice under the statutory procedures and that the Board expressed an opinion on the independent medical report. Consequently, I have concluded that these failings constitute maladministration leading to injustice.

I am satisfied that as a consequence of this maladministration the complainant suffered the injustice of being denied a final response from the GP Practice and the complainant was left with the genuinely held belief that they had been denied the impartial and independent handling of the complaint.

I recommended that the Chief Executive of the Board issues a letter of apology to the complainant.

In respect of service improvements, I recommended that the Board liaise with the Department of Health, which is responsible for the document 'Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning' to reconsider the guidance document in respect of the issues raised by my investigation, particularly with a view to ensuring the guidance is clear in defining the roles and responsibilities of various parties to a complaint.

Health Service Provider – GP

Failures in antenatal care

The Complainant complained to me that she had suffered injustice as a result of the standard of care and treatment provided to her by both her GP Practice and by the Health and Social Care Trust midwives during her pregnancy. She became gravely ill with an undiagnosed life threatening illness and her baby died before delivery.

I found that the failure of the Trust midwives to refer the complainant for specialist review on either of two consecutive days, when her presenting condition indicated that an urgent investigation was required, amounted to maladministration

I found that the GP did not carry out an adequate examination the day before her emergency admission to hospital and failed to consider her medical and familial history alongside her presenting symptoms. I found that this examination was attended by maladministration which caused her an injustice in that she became gravely ill and her baby died. I was also critical of deficiencies in record keeping in the GP Practice.

Whilst I could not be certain that earlier intervention would have prevented the baby's death, it was clear that both the Trust and the GP missed opportunities to prevent the serious complications which threatened the life of the mother and thereby caused her a grave injustice. I therefore upheld this complaint.

I recommended that the Trust asks each of the midwives involved in her care to reflect on their own actions and what they learned from this case.

I recommended that the GP Practice ensures that each GP treating a pregnant patient becomes familiar with her hand held maternity notes and is thereby aware of her medical history and any other risk factors.

Both the Trust and the GP Practice accepted my findings and recommendations. By way of remedy for the injustice suffered as a result of the maladministration I identified, I asked each body to write to the Complainant with a full apology, in recognition of all the failings identified in my report.

Alleged failures in care (complaint not upheld)

The complainant in this case complained that there was a lack of urgency shown by his GP Practice and there was not sufficient consideration given to the symptoms he was exhibiting when he first presented in November 2012. He complained that this led to a form of Hodgkin's Disease progressing untreated during the period from early November 2012 until his diagnosis in late December 2012.

The complainant originally attended his GP in early November 2012, when it was noted that he was feeling generally well but complained of night sweats lasting 2 weeks. Over the following 5 weeks because of his deteriorating health he attended the Practice on several occasions. He was seen in the local hospital's Ear Nose and Throat (ENT) Department in late November 2012 when abnormal lymph nodes were noted. He was further reviewed at the GP Practice on 30 November 2012 and again on 14 December 2012 when he was referred to hospital for admission because he was presenting with abnormal symptoms. A

diagnosis of Hodgkin lymphoma was subsequently confirmed following a lymph node biopsy on 22 December 2012.

As part of my investigation, I sought Independent Professional Advice (IPA) on the medical aspects of the complaint from a GP advisor and a senior consultant Haematologist. Following receipt of this advice and consideration of the documentation in my possession, I did not identify maladministration by the Practice in the care and treatment provided to the complainant. I concluded that it was not unreasonable for him not to be admitted to hospital prior to 14 December 2012 given his previous medical history and the necessity for diagnostic tests to be carried out.

Inappropriate care and treatment

In this case the complaint related to the care and treatment provided by a GP Practice (the practice) to the complainant's late wife. The complaint was that if the doctor in the Practice had treated his late wife appropriately in the weeks leading up to her death by examining her, acting on the results of blood tests and admitting her to hospital, then the outcome of her illness might have been different. The complainant also considered that his wife was denied appropriate pain relief, hospital admission or the right to be placed under the care of a liver specialist in the final weeks of her life.

Following my detailed consideration of this complaint and having received independent medical advice I identified maladministration had occurred in a failure by the practice to make an arrangement to see and assess the complainant's wife following the noting of abnormal blood results and in a failure to order further blood tests following a consultation. I also found that maladministration had occurred with a failure in the record keeping and a failure in relation to a hospital referral letter.

However I did not uphold the complaint that the practice specifically refused to visit the complainant's wife or to examine her. I also did not uphold the complaint in relation to the provision of palliative care or that the complainant's wife should have been referred to hospital at an earlier time. Overall I found no evidence to suggest that earlier admission to hospital would have had a demonstrable effect or would have led to a different outcome for the complainant's wife.

I recommended that the Practice issue an apology to the complainant for the maladministration which I identified. I am pleased to report that the practice accepted my recommendation.

Standard of care and treatment (complaint not upheld)

I received a complaint about the care and treatment provided by the complainant's GP Practice over a two year period, in relation to the diagnosis of unexplained collapses. The complainant also complained about the GP Practice's response to a verbal complaint made by the complainant's spouse in December 2012.

The complainant had suffered occasional episodes of loss of consciousness from 2006. In April 2011 the GP referred the complainant to a consultant physician for investigations into the collapse episodes, and the results of these investigations were considered to be satisfactory. The complainant discussed the possibility of a cardiology review with her GP but this was declined. The complainant continued to attend the GP Practice with other issues and made

further references to collapses in September and October 2012. The patient-doctor relationship appears to have deteriorated towards the end of 2012 and the complainant moved to a different GP practice in early 2013.

I was satisfied that the doctors in the GP Practice did take appropriate action when the complainant contacted the Practice in October 2010 and September 2012 about recent unexplained collapses. I did not find that the GP's actions were attended by maladministration and I did not therefore uphold this issue of complaint.

In relation to the complainant's spouse's complaint, while I found some deficiencies in the practice's complaint handling procedures I did not conclude that there was maladministration leading to injustice to the complainant and I did not uphold this issue of complaint. I was however pleased to note that the GP Practice implemented improvements to its complaints handling processes in 2014.

Appendix C
2015-16 Workload and Performance

Appendix C

2015-16 Workload and Performance

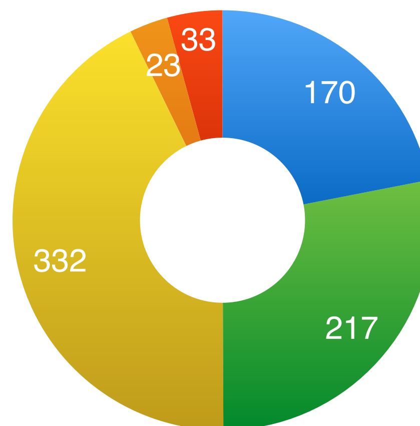
During the financial year 2015-16, 3,057 members of the public contacted the Ombudsman's Office - a 17% increase from the 2,607 contacts in the previous year. These contacts comprised 1,954 telephone enquiries, 361 written enquiries and 742 written complaints regarding maladministration.

Of the 742 maladministration complaints received, 170 were about bodies within the Ombudsman's jurisdiction as Assembly Ombudsman and 549 were about bodies within the Ombudsman's jurisdiction as Commissioner for Complaints. The remaining 23 maladministration complaints were found upon assessment to be outside the Ombudsman's jurisdiction

Of the 549 Commissioner for Complaints' cases, 332 were about Health and Social Care (HSC) bodies and 217 were about other bodies.

In addition to the above, in 2015-16 the Ombudsman received 33 complaints about alleged breaches of the Northern Ireland Local Government Code of Conduct for Councillors.

Summary of written complaints received in 2015-16:



In relation to maladministration, during the reporting year the Ombudsman reported on 134 issues of complaint. In 75 (56%) of these issues the complaint was upheld. In 59 (44%) of the issues no maladministration was found. However in nine of these cases the Ombudsman found there to be grounds for some criticism of the body complained of.

Agreed settlements between the complainant and the body complained of were achieved in 26 cases.

How we measure performance

Delivering operational efficiency, efficiency and accountability continues to be a key priority of the Ombudsman, measured through key performance indicators. The performance indicators focus on the time taken to complete investigations. Complementary qualitative assessments are completed through established internal procedures. The Office's Key Performance Indicators (KPIs) are described below.

KPI 1: Measures how quickly we establish whether the complaint can be investigated by this Office. The aim is to inform the complainant within **2 weeks** or less of their complaint being received. Target: 90%;

KPI 2: Measures how quickly we complete our assessment of whether a complaint should be investigated by this office or is suitable for settlement. Assessment is a detailed process which involves considering the complaint and the supporting evidence from both the complainant and the body complained of. This represents case-building in the event a case proceeds to investigation. We aim to complete the assessment process and inform the complainant of the decision within **10 weeks** or less of their complaint being received. Target: 70%;

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 50 weeks or less of the decision being made to investigate. Target: 70%;

KPI 4 (LGES): The Commissioner 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. Target: 85%;

KPI 5 (LGES): The Commissioner 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. Target: 85%.

The Office achieved four out of five of the investigative targets set for 2015-16, as shown in the following table:

KPI	Target	Result for reporting period
1	90%	95%
2	70%	76%
3	70%	55%
4	85%	86%
5	85%	100%

KPI 1 was met in 95% of cases, well ahead of the 90% target. The average number of days taken to reach the "can we investigate" decision was 6 – a very notable reduction from the 10 reported in the prior year.

The reported percentage performance for KPI 2 (the "should we investigate" decision) was also well ahead of target at 76% of cases against a target of 70%. The average number of days taken was 59 – again well down from the average of 69 days reported in respect of the prior year.

Following on from the "should we investigate" decision, the KPI 3 performance target fell significantly short of target. It was met in 55% of cases against a target of 70% and the average number of days taken was 402. This is reflective of the deliberate focus that was placed in 2015-16 on resolving a considerable number of older, more complex cases. As a result cases closed during 2015-16 included a large number of such cases carried forward from earlier years. Hence reported performance in the period fell substantially below target.

It is expected that this skewing of performance will recur in 2016-17. I am aware of a clear on-going trend towards increased case complexity that invariably acts to increase completion times. As with all our performance measures this area remains under regular review to ensure that the Ombudsman sets appropriate targets and that our monitoring systems are used to report on achievement in a way which enables us to best understand what is driving our business and in the best interests of our stakeholders.

Regarding KPIs 4 and 5, in respect of Local Government Ethical Standards (LGES), the 2015-16 complaints caseload position is summarised in the table below:

Caseload	2015/16
Complaints ongoing from previous year	9
Written Complaints Received in year	33
Total complaints under investigation in year	**42**
Number closed at Initial Assessment Stage "can we investigate?"	12
Number closed at Assessment Stage "should we investigate?"	16
Number of Complaints Withdrawn	1
Number determined at Investigation Stage	3
Number of Complaints Ongoing at year end	10

KPI 4 (the decision whether to investigate) was reached within the 4 week target in 25 out of the 29 cases that were considered in 2015-16 – representing an 86% achievement rate against a target of 85%.

KPI 5 (completion of the investigation within 48 weeks of the decision to investigate) was achieved in all three (100%) of the cases that reached that stage during 2015-16, against a longer-term target of 85%.

In view of the relatively recent introduction of the Code (May 2014) and the difficulty, at this early stage, in predicting the future volume of cases, the Office does not propose at this point to shorten the target timescales for completion of an investigation, but will continue to keep the relevant target under review.

Appendix D
Financial Summary 2015-16

Financial Summary 2015-16

The Assembly Ombudsman for Northern Ireland and the Northern Ireland Commissioner for Complaint's (AOCC) full Annual Report and Accounts for 2015-16 have been laid before the Northern Ireland Assembly in June 2015 and are available on our website at www.nipso.org.uk.

Summary Financial Statements for the year ended 31 March 2016

The following Financial Statements are a summary of the information extracted from the detailed Annual Report and Accounts for 2015-16, which should be consulted for further information.

The Comptroller and Auditor General has provided an unqualified audit opinion on AOCC's Accounts for 2015-16.

Financial Performance

Two of the four financial targets set by the AOCC in 2015-16 were met, with the remaining two being partially met.

The authorised Net Total Resource and Net Cash Requirement and Capital expenditure levels were not exceeded within the reporting period. However the target level of underspend was exceeded.

The resource and cash results for 2015-16 are summarised in the following Table:

	Estimate	Outturn	Saving/ (Excess)	Actual % saving/ (excess)	Target % saving/ (excess)
	£k	£k	£k	%	%
Gross Resource Outturn	2,043	1,956	87	4%	2%
Income	5	5	-	-	-
Net Resource Outturn	2,038	1,951	87	4%	2%
Capital	4	2	2	50%	2%
Net Cash Requirement	2,280	2,041	239	10%	Not to exceed estimate (target met)

The main reasons for the variance between Estimates and Outturn are:

- a reduction in salaries expenditure occurred due to unplanned staff departures and unpaid leave (on compassionate grounds) in the final quarter of the reporting period. The financial position was also affected during the reporting period by the timing of the passage of the new NIPSO legislation. This resulted in a number of significant expenditure areas, such as training and recruitment, being delayed and a decrease in actual costs against those forecast for the latter part of the reporting period. This delay was outside the direct control of the AOCC and resulted in both a reduction in salaries, due to unfilled vacancies, and a reduction in associated recruitment costs which had been forecast for 2015-16;

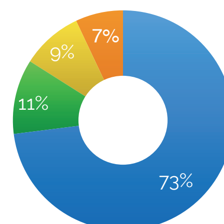
- depreciation was lower than that forecast due to a mid-year reduction in capital resource and therefore a decrease in associated depreciation charges. The reduction was reallocated to aid with forecast pressures at that time and enable a reduction in an in-year bid. The AOCC, after review, re-lifed a number of assets to allow for the reallocation of the resource rather than replacement, which additionally impacted on the forecast depreciation charge;

- professional medical and social work advice costs were less than that forecast. These costs are demand driven. During the first half of the reporting period there was a significant increase in the demand and as such forecast full year costs were adjusted to reflect the increase, however demand reduced in the latter half of the reporting period at which point there was no opportunity to re-adjust the AOCC estimates, and;

- timing of final in-year monitoring exercise. The November 2015 monitoring exercise was the last opportunity to adjust the estimates and resource requirements in terms of bids or reduced requirements for 2015-16. A number of the major movements, particularly reduced requirements outside the control of the AOCC, arose in the latter part of the financial year by which time the AOCC had no opportunity to adjust its estimate.

As illustrated below, far and away the largest area of expenditure for the AOCC continued in 2015-16 to be in permanent staff costs (73%)

Note: Above expenditure percentages based on Net Resource Requirement less non cash costs, Consolidated Fund Standing Services and non service expenditure.



Prompt Payment of Suppliers

The AOCC places a high degree of emphasis on paying correctly presented invoices quickly. In 2015-16 we had a target to pay 98% of such invoices within 10 days of receipt. We achieved payment within 10 days of receipt of a correctly presented supplier invoice in 99% of cases (98% in 2014-15).

Contacting the Office

Access to my office and the service I provide is designed to be user-friendly. Experienced staff are available during office hours to provide advice and assistance. Complaints must be put to me in writing either by letter or by completing my complaint form; the complainant is asked to outline his/her issues(s) 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 (but note that this is no longer a requirement upon the establishment of the Northern Ireland Public Services Ombudsman on 1 April 2016). 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; and through libraries, advice centres, etc. Anyone requiring alternative formats or 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 E-mail to: nipso@nipso.org.uk

By writing to: Freepost NIPSO

By calling, between 9.00am and 5.00pm, at:

Northern Ireland Public Services Ombudsman
Progressive House
33 Wellington Place
Belfast
BT1 6HN.

Further information in respect of the new Northern Ireland Public Services Ombudsman (NIPSO) is available on my Website:

www.nipso.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

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Progressive House
33 Wellington Place
Belfast
BT1 6HN

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