NIPSO

Ombudsman's Report 2021 – 2022

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Foreword from the Ombudsman

I am pleased to introduce my Ombudsman's Report for 2021 – 2022. During this year we developed a new NIPSO strategic plan with themes focused on accessibility, engagement, delivering excellence and making a difference. We have also chosen to present the Ombudsman Report differently this year and have highlighted our work by using three broad thematic areas:

1. **Making a difference for individuals**
2. **Making a difference through systemic change**
3. **Making a difference through service improvement.**

I believe these broad areas more effectively reflect not just the work of the Ombudsman office but our overall impact and effectiveness. The difference that we make in people's lives and to public services.

This was an important year for NIPSO. The number of individual complaints received by my office increased by 30% across the year with the long term trend on complaints continuing to show a steep increase; an overall rise of 125% since NIPSO's establishment in 2016. The report shows the breadth of our work, and the summaries show how we have helped resolve complaints and achieved real outcomes for people.

This year we also launched our first Own Initiative Report into the Use of Further Evidence within the PIP process. Our finding of systemic maladministration showed repeated failings in how both Capita and the Department for Communities used this evidence to assess entitlement to PIP. We continue to follow up on how our recommendations for improvement are being addressed.

We also achieved an important landmark when Part 3 of our 2016 NIPSO legislation was approved by the Northern Ireland Assembly. This means we can begin to move forward on making it much simpler and more straightforward to make a complaint to any public service. This is a huge task, which will take some time, but the benefits, I believe, will be felt by everyone.

After another busy year I would like to thank NIPSO staff for their continued hard work, resolve and dedication. I would also acknowledge the co-operation of public bodies who continued to respond to our requests for information quickly and efficiently in the face of extremely difficult circumstances.

We all depend on public services, but when things go wrong everyone has the right to complain. I believe this report illustrates the value and importance of complaining and how we can improve public services while also ensuring access to justice for individuals.

Margaret Kelly

Margaret Kelly

Ombudsman
January 2023

Introduction

During 2021-22 NIPSO carried out a series of consultations with staff and external stakeholders to develop a new Strategic Plan.

This was launched in May 2022 and sets out **five strategic themes** to connect and drive our work over the next three years.

These are:

Accessibility

Engagement

Making a Difference

Delivering & demonstrating value

Innovation and modernisation

A key ambition is to become a more accessible and inclusive organisation which can demonstrate outcomes for the public from our work.

Making a Difference

NIPSO is committed to sharing the learning from our investigation work and using investigations to:

- provide redress,
- inform improvement and;
- make a positive change for people, public services and public policy.

Some of the significant achievements in 2021-22 are highlighted in the next sections.

What We Do

Purpose

Investigate unresolved complaints about public bodies, uphold standards and ensure accountability for both public bodies and for local Councillors.

Contribute to broader improvement by sharing the learning from both individual complaints and systemic reports.

Vision

Make a positive difference to people and public services in Northern Ireland by providing individual resolution and improved services through learning from complaints.

Core Functions

- Free, independent investigation of unresolved complaints.
- Providing redress and resolution of injustices suffered by individuals.
- Improving public services by sharing learning from complaints

Values

Our values underpin all aspects of our work and how we engage internally and externally.

Independence

We are open, non-partisan, unbiased and we act with integrity.

People Focused

We treat people with respect and empathy and recognize and value individual experience. We are accessible and engage and explain our decision making.

Fairness

We are honest and impartial, ensure all views are listened to and use an evidence-based approach to our decision making.

Excellence

We deliver an excellent service, meeting our service standards with high levels of governance and accountability. We have a focus on continuous learning and improvement.

Who can people complain about?

Health and Social Care

For example, Hospitals, Trusts and Nursing Homes

Housing

Housing Executive and Housing Associations

Education

All schools, college and universities

Local Government

All 11 Local Councils

Central Government

All Northern Ireland Government Departments and their Agencies

Making a difference for individuals

2.1 Individual Complaints from the public

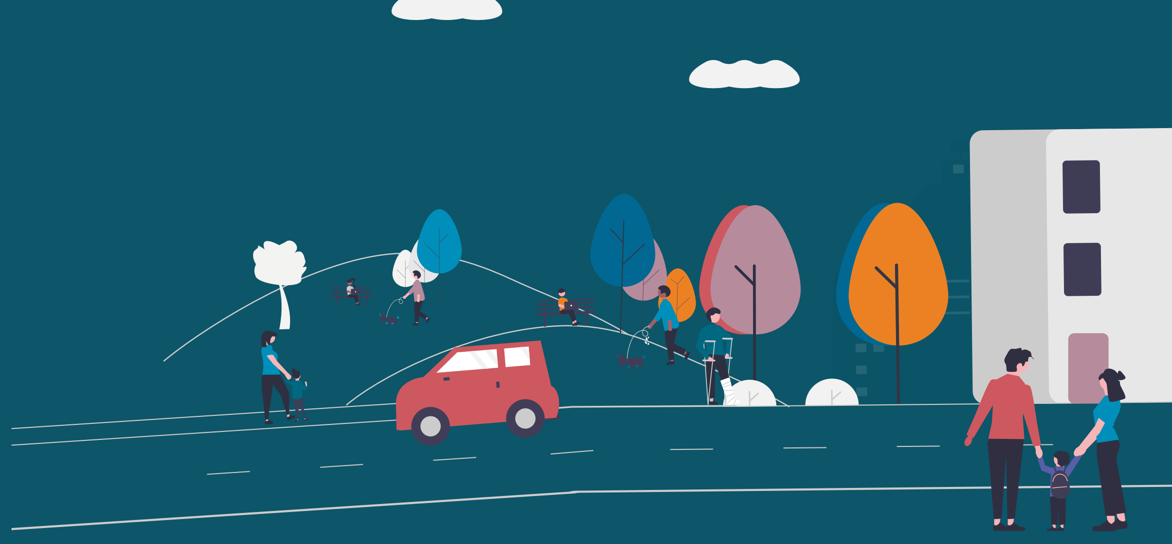
During the year we received 1211 complaints from the public.

This was a 30% increase in complaints from the previous year and resulted in an increased number of cases (up 23%) progressing to the second stage of the investigation process. NIPSO continue to focus on achieving early resolution of complaints where possible and during 2021-22 the ASSIST team successfully resolved 65 cases via settlement.

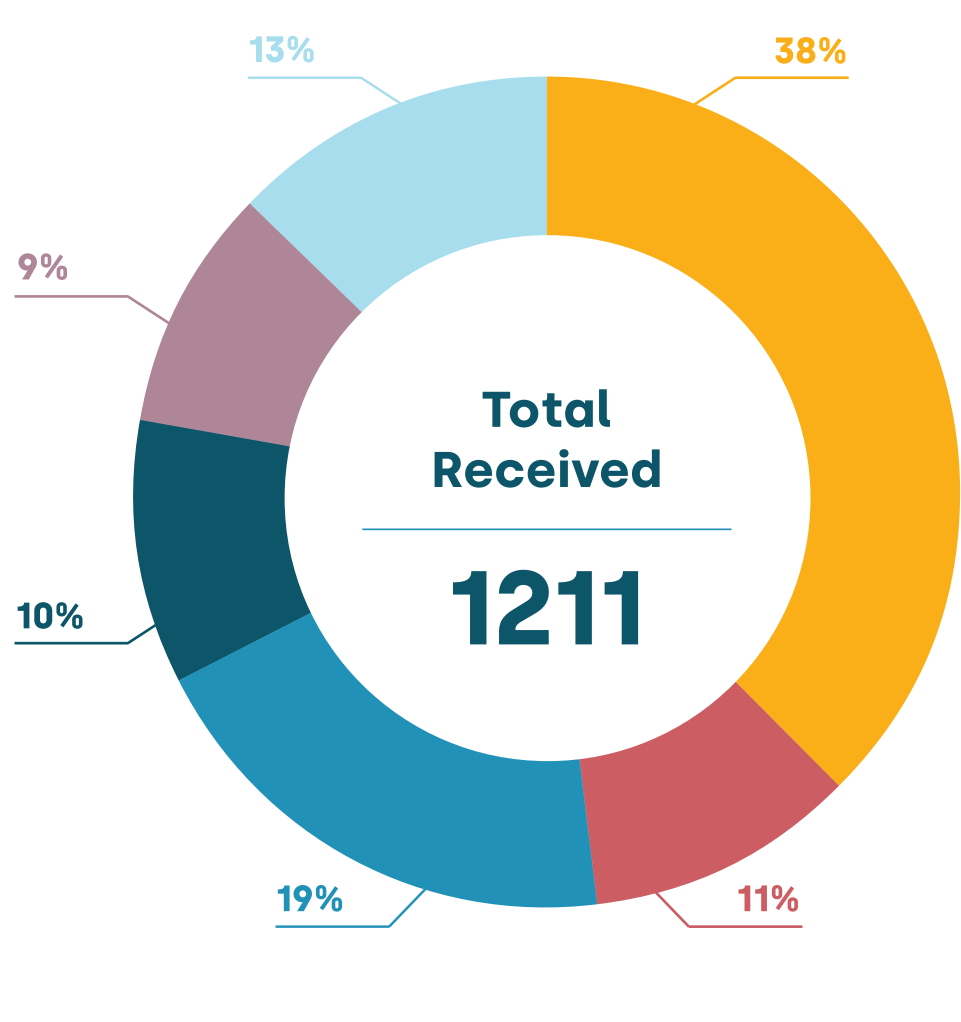
This emphasis on achieving resolution enables NIPSO to focus resources on those cases which warrant further investigation, whilst still achieving beneficial outcomes in a timely manner for complainants. In addition, 21 cases were referred back to the body for further local resolution where this was considered an appropriate mechanism to achieve a beneficial outcome.

This type of resolution can be an effective means to achieve an alternative and speedier resolution of complaints, particularly in cases concerning poor complaints handling by that body. This approach is useful where there is an ongoing relationship between the complainant and the public body, and it enables trust to be rebuilt.

The number of cases which progressed to the further Investigation stage, also increased significantly (29%) on the previous year. It is notable that there has been a steady overall increase of 51% over the past 5 years in the number of cases accepted for further investigation. This year the Office completed the further investigation and issued a final report for 84 cases.



Breakdown of 2021-2022 Complaints



Health & Social Care
Housing
Councils
Education
Gov Departments
Other

2.2 Individual Case Studies

1. Investigation found ‘significant’ failures in care of Downs Syndrome patient in Belfast City Hospital

This complaint was in relation to the care and treatment the staff of the Belfast City Hospital (BCH) provided to the complainant’s brother, who had Downs Syndrome and also suffered from dementia.

Our investigation found that the patient was given inappropriate food to eat and was offered food when he was ‘nil by mouth.

Despite the availability of tools and resources designed for the purpose, we found that the Trust failed to use any kind of pain tool to assess and record the patient’s pain and distress. This was a particularly significant failure as the man was unable to verbalise his needs.

Commenting on the investigation, the Ombudsman said: ‘The Trust’s failures in this case were significant. Our investigation highlights the need to continue to raise awareness and improve practice for some of the most vulnerable patients within the hospital system. The failings in relation to care of the patient were compounded by the added distress for the family arising from poor complaints handling.

This is why I have asked the Trust to apologise to the complainant, as well as recommending a number of improvements in relation to end of life care, better coordination between medical teams, and staff training.’

The investigation noted the improvements already identified by the Trust and welcomed the new Learning Disability resource on the Trust’s internal website.

2. Debt cancelled following complaint about Land & Property Services

A man complained that he was unfairly penalised when he recommenced work after a short period on Universal Credit.

Despite informing the Land and Property Services (LPS) of his return to work, he continued to receive a rates rebate. Five months later he received a demand to return the money which had accumulated. Although it was acknowledged that he had informed the LPS of his return to work, he was told he did not contact the right department.

We made enquiries with the LPS, who agreed to submit the case to its Shortfall in Service panel.

The panel decided that because of the poor level of service he received, the man was entitled to a 100% reduction in his liability. This equated to a write-off of over one thousand pounds. The LPS also provided him with an apology for the poor level of service he received.

3. Housing Executive failed to deal with claims of anti-social behaviour (ASB)

A man complained about the way the Housing Executive dealt with his concerns about episodes of Anti-Social Behaviour (ASB).

We examined the details of the complaint, the NIHE's response, and relevant internal guidance.

The NIHE explained it did not record the concerns as ASB incidents. However, we found that the man's reports met the NIHE's definition of ASB and that it should have managed them in accordance with its ASB Manual. We also established the NIHE failed to acknowledge or respond to the man until after he submitted his sixth report, which was nine months after his first.

The NIHE identified two telephone conversations it had with the complainant regarding his concerns. We were unable to determine if the NIHE's actions were appropriate, as it did not provide contemporaneous records of the calls.

We were satisfied that the failures caused the man to lose confidence in the NIHE's ability to manage his complaints about anti-social behaviour, and asked it to apologise.

4. Serious failings may have shortened mother's life

A woman brought a complaint about the poor care her mother received at a Care Home and which she described as 'seriously inadequate and totally unsatisfactory.' A detailed investigation found that in one incident her mother sustained a fractured leg while being moved by staff and then experienced a full day's delay before the injury was identified. In a second incident poor oral health care led to a delay in finding her mother's dentures lodged in her throat.

Our investigation established that the complainant's mother's dentures were lodged in her throat for up to 24 hours undetected. We found on balance that the home's failings in the care and treatment of the resident were preventable, and that the incidents may well have contributed to the shortening of her life.

Commenting on the case, Ombudsman Margaret Kelly said: "I understand that this report will have made distressing reading and I recognise the emotional impact on a family in bringing a complaint of this nature forward. It is a testament to the love and devotion they had for their mother that they want to ensure no other family suffers a similar experience."

As well as recommending the apology, we also asked the home to carry out staff training and service improvements in oral hygiene, and in the moving and handling of elderly residents.

Making a difference through Systemic Change

3.1 'Own Initiative' Investigation into Personal Independence Payments

We are able to launch investigations where there is a reasonable suspicion of systemic maladministration. The issue of concern needs to be in the public interest and affect a number of people or a particular group of people.

In June 2021 we launched the report of the first 'Own Initiative' Investigation to be conducted by any Ombudsman office in the UK. The investigation focused on the use of further evidence in the assessment of Personal Independence Payments (PIP). It examined the processes and systems used by the Department for Communities (DfC) and Capita and found that they failed to properly obtain and use all relevant health and other information when assessing PIP benefits. It also identified issues with communication and clarity of processes for participants, many of whom are among the most vulnerable people in society.

The failures identified have a significant impact on individuals waiting on their PIP benefit. We found that individuals were sometimes wrongly informed that all health professionals had been contacted, when this was not the case.

Many people had no choice but to challenge the decision, often all the way to Appeal before the correct decision was made. It was often only at the appeal stage that the further evidence was fully considered. This creates a lengthy and stressful delay which, for many people could have been prevented had the correct evidence been considered earlier in the process. In addition to the stress and financial impact on individuals there is also economic consequences for the public purse. It is estimated that PIP appeal costs, between April 2017 and March 2021, were nearly £14 million.*

The investigation made a total of 33 recommendations to DfC and Capita to improve the system and address the identified maladministration. These recommendations are aimed at promoting a more transparent and accessible system which is more customer focused. The office has maintained regular contact with DfC to monitor the progress of the recommendations and will be launching a follow-up report in 2023.

Ref. The Management and Delivery of the Personal Independence Payment Contract in Northern Ireland. Report by the Comptroller and Auditor General. 23 March 2021.

Case Summary
Restraint and Seclusion

A parent brought a complaint to NIPSO raising concerns about the use of restraint and seclusion after learning that their 6-year-old child had been placed in an 8 x 4-foot room for the purposes of seclusion.

The parent said there was no natural light in the room and that the door had a lock ' to stop children escaping'. The experience had a significant adverse impact on the child, and the parent had concerns about how the school handled their complaint.

The NIPSO investigation found a number of failings including - a lack of records on how many incidents of restraint and seclusion had occurred; a failure to inform the child's parent of these incidents; no policy for staff on how the room should be used; a lack of training for staff looking after the child; and that staff taking the child to the room failed to act in line with the school's Reasonable Force policy in relation to the use of restraint.

3.2 The use of Restrictive Practices in Schools

In response to a number of individual complaints highlighting concerns around restrictive practice, the office conducted a Strategic Enquiry into the use of restrictive practices in schools in NI. In analysing the individual maladministration investigations, we identified a number of recurring issues of concern in relation to restrictive practices. This included a lack of appropriate records; inadequate consultation with and information to parents; a lack of appropriate, up-to-date policies and procedures and inadequate complaints handling by Boards of Governors.

A report sharing our findings was published in May 2021. Using case examples from investigations brought to the office, our report highlighted the significant, negative impact that inappropriate use of restraint and seclusion can have on a pupil and the accompanying anxiety that poor communication can create for their parent or carer.

One parent stated *'A child has a right to feel safe in school, I want school staff to be held to the same safeguarding standards as parents and health professionals'.* Another shared that their child now receives counselling and has developed a mistrust of school staff after inappropriate intervention involving restrictive practice.

As part of our enquiries the office engaged with the Department of Education, the Education Authority, the Council for Catholic Maintained Schools, the Controlled Schools Support Council and the Education Training Inspectorate in order to understand the nature and frequency of restrictive practice in schools.

The responses to the enquiry identified that at that time, there was little to no regulation undertaken in regard to the use of seclusion and/or restraint. Policy and guidance in relation to seclusion did not include a clear definition of what 'seclusion' is and the policy and guidance around restraint was very outdated. Indeed, much of the detail in relation to restrictive practice was left to the discretion of individual schools' policy. On occasion it is entirely appropriate that school staff may need to use what is described as 'restrictive practice'. However, the lack of regulation or guidance around recording and monitoring of restrictive practice presented a concerning picture with inconsistent practice across schools.

At the time of the report launch in May 2021 a number of significant undertakings were made or were already underway to address many of the issues identified. This included a Department of Education review of restraint and seclusion and a public commitment to making improvements. The Department also published interim guidance to schools while the review is ongoing. A number of reviews by other organisations offered additional insight into the current issues and considerable work was ongoing by Parent and Advocacy groups and the NI Children's Commissioner for Children & Young People. There was also continued support for legislative change from the Committee for Education.

Although outside of the timescale of this Ombudsman Report it is important to highlight the progress made. In March 2022, the Department published its review of the use of restraint and seclusion in educational settings. One of the key commitments is to issue statutory guidance during 2022/23. This statutory guidance will provide clarity on the definition of seclusion, and it's use, a definition of restraint and clarity that it should only ever be used as a last resort and further clarity that restraint practices must never inflict pain on children and young people.

3.3 Transforming the Complaints Landscape

This was an important and exciting year for our work on complaints standards as we seek to simplify and improve the process for making a complaint across the public sector in Northern Ireland. Once implemented, this means that whether a complaint is about a school, a hospital or a council, the same procedure and timescale will be applied. This will transform the complaints landscape; complainants will know what to expect when they make a complaint and how long their complaint will take. The new standards will also require the publication of complaints information and evidence of how public bodies are learning from complaints data.

Some of this year's significant milestones included publishing our research into complaints handling by public bodies (June 2021). We found that two thirds of people who were unhappy with the level of service from a public body said they would not complain as they thought it would make no difference or be considered too trivial. We are committed to changing this and developing a complaints system that has public confidence.

Complaints Standards Statement of Principles

Key findings from survey

30% 30% of respondents had been dissatisfied with service from a Public Body

30% Only 30% of whom had made a complaint

63% Of those who did complain, 63% considered the matter 'unresolved'

60% Over 60% of complaints can take over 15 days to achieve an initial response

[Complaints handling in the public sector in Northern Ireland June 2021.]

Rather than being seen as unwelcome distractions, complaints should be treated as a source of user feedback, providing organisations with an excellent opportunity to question how they deliver services.

Ombudsman Margaret Kelly

We also launched a consultation on our draft plans to create a common set of complaint handling standards for the whole of the public sector. The findings, published during the year, highlighted that the majority of respondents (members of the public and public bodies) welcomed the proposed changes to complaints handling and supported our approach to implementing the new standards.

Most importantly, in January the Northern Ireland Assembly approved our Statement of Principles. These six principles set out the basic approach public bodies should take when dealing with complaints from members of the public.

This approval meant that were able to begin work with the local government sector which was selected as the first sector to put in place the new procedures. NIPSO's role includes facilitating a Strategic Network of local government sector leaders to support cultural change as well as policies. We will also support the new approach with staff training, resources and a range of guidance. We have also been engaging with the health and social care sector to introduce the changes within this complex sector on a phased basis.

Making a difference through Service Improvement

4.1 Analysis of Investigation Recommendations

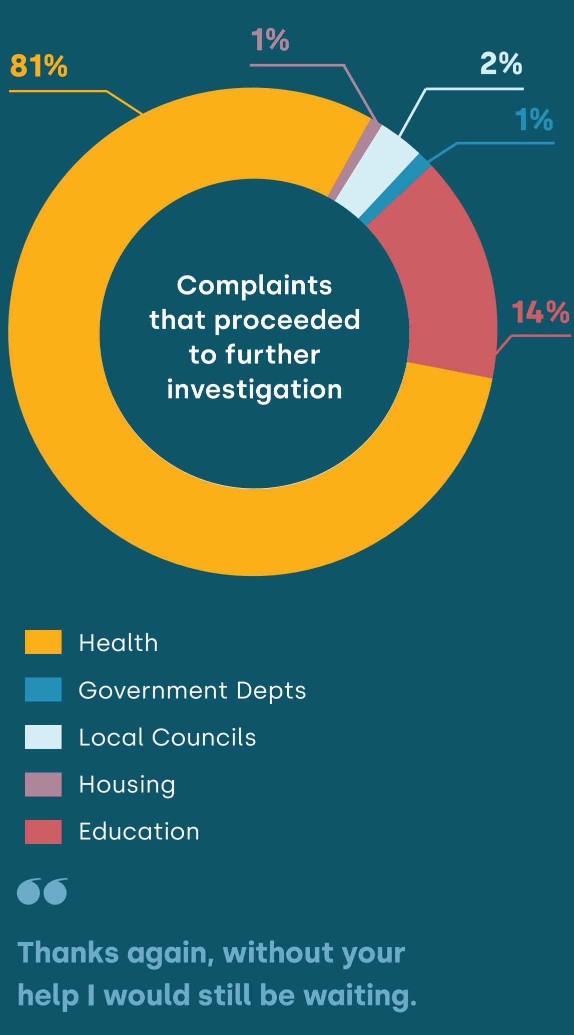
Findings and learning from 'Own Initiative' investigations, the Complaints Standards Project and individual complaints investigations are all used by the Office to help inform improved service delivery by public bodies. Investigations of individual cases include a comprehensive review of all relevant documentation and policies / guidance and receipt of Independent Professional Advice from experts in areas such as medicine, health and social work.

A key component in any investigation where maladministration is found is using the complainant's experience and the available evidence to make recommendations for service improvement. A key driver in people bringing complaints to us is **to prevent this happening again to someone else.**

During 2021-22, 84 individual investigations were completed with the issuing of a final report to both the complainant and the relevant public body. In 13 investigations the complaint was not upheld - this means that evidence of maladministration was not found.

However, in the remaining 72 cases the issues brought by the complainant were either upheld in full or partially upheld. In considering the injustice experienced by complainants, the Ombudsman stipulated that the public body make an apology to complainants in 64 of the cases investigated.

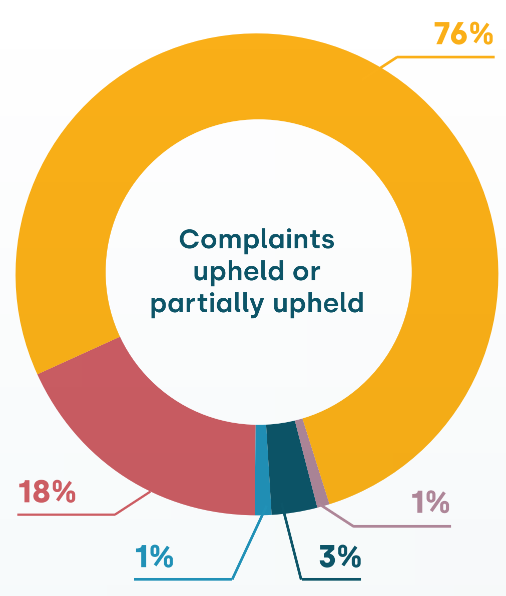
2021-22 Final investigation reports by Public Body.



> **Thanks again, without your help I would still be waiting.**
>
> *Complainant*

I would like to thank Investigating Officer for his professionalism, kindness and sympathy in which he dealt with this investigation.

Complainant



Percentage of complaints upheld either in full or partially after investigation

- Health
- Government Depts
- Councils
- Housing
- Education

The investigator took the time and patience to listen to me for which I am very grateful.

Complainant

Promoting a culture where public bodies learn from mistakes and take steps to prevent the issue from re-occurring is an important outcome of investigations. To facilitate this, investigation reports make a wide range of specific recommendations with timescales for implementation. In 2021/22 the Office made a total of **215 recommendations for service improvement.** These recommendations are frequently accompanied with requests for specific evidence to help monitor the implementation of the recommendations.

This year investigation reports included **77 specific requests for evidence of implementation and compliance** with the recommendations made. Examples of evidence can include training records, minutes of staff meetings, copies of staff communications, updated policies and procedures, audit and review outcomes and detailed action plans.

A breakdown of the 215 recommendations made by the Office can be seen below. In all cases the public body accepted our recommendations.

Area for Improvement	Number of Recommendations
People / Staff	115
Policies / Procedures	96
Other	1
Reimbursement or Refunded Payment	1
Systems / Processes	1
Total	**215**

Recommendations for '**Policies/Procedures'** typically involve asking a Public Body to review or revise a policy or procedure in line with the regionally recognised policy or good practice guidelines.

Examples of this include:

- Recommendation that the Trust either individually or collectively with other HSC organisations address the confusion around Continuing Health Care (CHC) applications and develop the necessary guidance and procedures for the Single Eligibility Criteria.
- Recommending that a Trust undertake a review of how the Palliative Care team and the Care of the Elderly are coordinated, incorporating existing best practice between the Palliative Care team and the Oncology service.
- Asking a Dentist Practice to review its policies to ensure they are compliant with the General Dental Service Regulations and ensuring that any updated policies are brought to the attention of staff.
- Asking a Care Home to introduce a process to monitor practice in relation to resident safety and also to ensure that pre-admission care planning and risk assessments include the family input.

Capturing the impact of the individual case recommendations will be an important feature of the Office going forward.

In addition to monitoring compliance with the requests for evidence the Office is developing a strategy to carry out more detailed follow-up on a small number of cases to better understand and learn from the impact of the recommendations made.

Recommendations for **'People/Staff'** most often involves the training (or re-training) of relevant staff in a particular practice or skill.

Examples in 2021 -22 include:

- Nine school complaints where it was recommended that Board of Governors receive training in Complaints Handling and / or Record Keeping.
- That a Trust engage the help of a Learning Disability Acute Liaison Nurse to provide training for staff who care for patients with a learning disability. The training to include a focus on good communication with patients and families. The Trust was also asked to develop an online learning disability resource on caring for people with learning disabilities.
- Asking a Care Home (within three months of the final report) to provide training to relevant staff on the recognition of potential stroke symptoms and the steps to take when a stroke is suspected.

I want to thank you so much for your intervention. I have just received an email from [the public body] and hope the complaint process will now follow a timeline.

Complainant

Engagement and Outreach

To help inform our own service improvement, during the year we commissioned a Customer Satisfaction Survey. Over 200 interviews were carried out with individuals who had submitted complaints to us in the previous two years.

The survey helpfully highlighted areas of our service where we are doing well and where there are opportunities to improve. The key messages and findings from this survey strongly align with the commitments made in our Strategic Plan and our Business Plan to continue to improve the service people receive from us. More information can be found at nipso.org.uk.

During the year we also carried out a Public Awareness Survey. The purpose of this survey was to better understand attitudes to complaining about public bodies in Northern Ireland, awareness of the office, and views about our work.

The survey found that **40%** of people questioned had heard of NIPSO. Of these, **96%** felt that they could approach NIPSO if they needed to and that **92%** believed NIPSO investigates complaints impartially. A total of **88%** of those who had heard of NIPSO said that they had confidence in our work.

During the year we continued to meet with individuals and groups to explain our work and understand the needs of others. Our staff engaged with representatives of health trusts, local councils and government departments to understand how public services and complaints were being impacted by the continued restrictions brought about by the pandemic.

However, we recognise that we have more work to do to become a more widely understood and accessible organization. To help with this, this year saw the establishment of an Improvement, Engagement & Impact team. This exciting development will build our capacity to be more engaged with both the public and public bodies.

Meeting with the advocacy group Care Home Advice and Support NI (August 2021)

Promoting NIPSO at the Balmoral Show (May 2021)

We also continued to promote the Office via a mixture of online activity and, where possible, in-person events, including the Balmoral Show. Our digital presence has grown too. We are more active across social media, helping us to engage with members of the public, as well as key stakeholders.

Introduction

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

Background

A wide-ranging review of the criminal justice system in Northern Ireland concluded in March 2000. One of its recommendations included the appointment of a person to oversee, monitor and audit the existing appointment procedures for judicial roles. This in turn led to the creation of the role of Commissioner for Judicial Appointments who carried out a review of the existing processes for appointing judges. Following the passage of legislation, this resulted in the establishment in Northern Ireland of Northern Ireland Judicial Appointments Commissioner (NIJAC) in 2005 and the Northern Ireland Judicial Appointments Ombudsman (NIJAO) in 2006.

Legislation and Status

The 2002 Act provided the statutory framework for the establishment of the Northern Ireland Judicial Appointments Ombudsman. Sections 9A to 9H of the 2002 Act defined the arrangements for investigating complaints which were made to both NIJAC and to the Judicial Appointments Ombudsman respectively and how they were to be reported.

The 2002 Act provides for the Judicial Appointments Ombudsman to submit a report at the conclusion of each financial year. Following the devolution of policing and justice matters to the Northern Ireland Assembly in April 2010, such reports were laid by the Minister of Justice before the Assembly. However, the legislation governing the procedures for laying a report were amended by the Public Services Ombudsman Act (Northern Ireland) Act 2016 (the 2016 Act) to provide for the report to be laid before the Assembly by the Ombudsman. Copies of previous Annual Reports can be obtained from the website www.nipso.org.uk

The statutory role of the Judicial Appointments Ombudsman is defined as a corporation sole and is independent of the Assembly, Government, the judiciary, NIJAC, the Northern Ireland Courts and Tribunals Service or the Department of Justice (Northern Ireland).

Complaint Activity 2021-22

During 2021-22 no complaints about NIJAC were received by the Judicial Appointments Ombudsman.

GET IN TOUCH

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