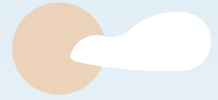
Northern Ireland
Public Services
Ombudsman



Ombudsman’s Report
2022 – 2023

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Foreword from the Ombudsman

I am pleased to introduce my Ombudsman's Report for 2022-23. NIPSO aims to make a difference for people and public services in Northern Ireland by investigating complaints and driving improvement in public services through ensuring the lessons are recognised and implemented.

We have a unique role in providing a space for redress for individual citizens which is free, independent, and accessible and by providing opportunities for change, learning and improvement for public bodies.

This year we consulted on and introduced a new strategic plan with a focus on engagement and accessibility. Our surveys and research in preparing our new plan indicated that too many citizens in Northern Ireland were unaware of how and when to access NIPSO services. This was particularly true for those individuals and groups who are furthest away from access to justice.

As Ombudsman I want to ensure that everyone who needs our service can access it easily and that where there are barriers we work to address and overcome these. So, in launching our new strategic plan we have created a new engagement and impact team which has been working across the year to engage a wide variety of groups and individuals to help inform our work and approach and to raise awareness of our services.

This report shows the breadth and impact of our work. From making a difference for individuals at every stage of our investigative process, to making a difference through service improvement and highlighting and driving the need for systemic change via our Own Initiative powers and investigations.

This year we have shared our work by publishing more individual investigation reports as well as thematic case digests. We have engaged much more publicly, as well including two significant surveys in our Own Initiative investigation into the communications people on health care waiting lists receive. We had an overwhelming response with over 600 members of the public completing a survey and over 300 GPs. We have highlighted our work and its impact via the media and social media with the aim of ensuring all those who need access to justice via NIPSO know how to do so. We also highlight to public bodies the importance of learning from complaints and improving services.

We have also begun the process of driving real change in how all public bodies undertake their complaints process. We were provided with additional legislative powers through the commencement of Part 3 of the Public Services Ombudsman (Northern Ireland) Act 2016.
This year we began with local councils and the local government sector to agree a simplified, straight forward and short complaints procedure. We also began our engagement with the health and social care sector.

In the year ahead we will continue to expand our outreach and engagement including that with public bodies in implementing complaints standards and publish many more reports including our latest Own Initiative investigation. NIPSO can only make the difference we want to make by ensuring that our services are accessible and available and that those who use them are listened to and valued. We make many difficult decisions as an ongoing part of our work and often finely balanced judgements, but we do so independently and with the overall aim of providing redress and ensuring improvement. We will continue to do so.

I would like to thank NIPSO staff for their continuing hard work, resolve and dedication across the year and for ensuring we can fulfil our purpose. I would also like to thank those complainants and public bodies with whom we engaged this year.

Margaret Kelly
Ombudsman

The year in numbers

1,046 complaints

282 **recommendations** *made to public bodies*

79% of complaints at the Further Investigation stage *were fully or partially upheld*

94% increase in complaints *since the establishment of NIPSO in 2016.*

40% complaints relating to **Health & Social Care**

What we do

We investigate unresolved complaints about public service providers in Northern Ireland.

Following our investigations we may decide either that a public body acted reasonably, or that it behaved unfairly. If we find failings we will ask the body to put things right.

We promote good administration in public bodies and help improve public services by making recommendations to try and prevent mistakes being repeated.

The complaints we receive can be broadly broken down into **five main sectors:**

Health and Social Care

Housing

Education

Local Government

Central Government

Strategic Plan 2022-2025

In May 2022, after consulting internally and externally, we launched our new Strategic Plan. We undertook a number of surveys to help inform the development of the plan, including both a complainant satisfaction survey and a public awareness survey.

Our Vision

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

Our Purpose

Our purpose is to investigate unresolved complaints about public bodies, uphold standards and ensure accountability for both public bodies and for local Councillors. We also contribute to broader improvement by sharing the learning from both individual complaints and systemic reports.

Strategic Objectives

We want to ensure that all those who may be dissatisfied with public services know how to come to NIPSO, particularly for those furthest away from access to justice. On this basis our key themes are accessibility and engagement. The **five key themes** for us to deliver on by 2025 are:

Accessibility

1.1 Make all our services as accessible as possible by reviewing our accessibility and making necessary adjustments.

1.2 Ensure all our information is provided in a variety of formats and is easily understood.

1.3 Provide opportunities for those groups least likely to access NIPSO to engage with us.

1.4 Highlight issues of accessibility in public services through our Model Complaints Handling Procedure.

Engagement

2.1 Regularly engage with a wide range of stakeholders through the development of an engagement strategy - including the public, public services, support and advocacy groups and political representatives, to improve understanding of NIPSO's role and work.

2.2 Increase the awareness and understanding of NIPSO's work through a range of media including social media.

2.3 Use our Own Initiative Investigations to address matters of wider public interest.

2.4 Promote greater understanding and awareness of our work by publishing a range of investigation, thematic and other reports.

2.5 Promote and engage on the Councillors Code of Conduct to improve understanding and contribute to standards in public life.

Making a Difference

3.1 Make recommendations to ensure appropriate redress for individuals.

3.2 Use data and trends from our work to help drive wider improvements.

3.3 Use the learning from our work to influence wider change in public policy and services.

3.4 Respond to public consultants or calls for evidence where our case work evidence can make a difference.

Delivering & demonstrating value

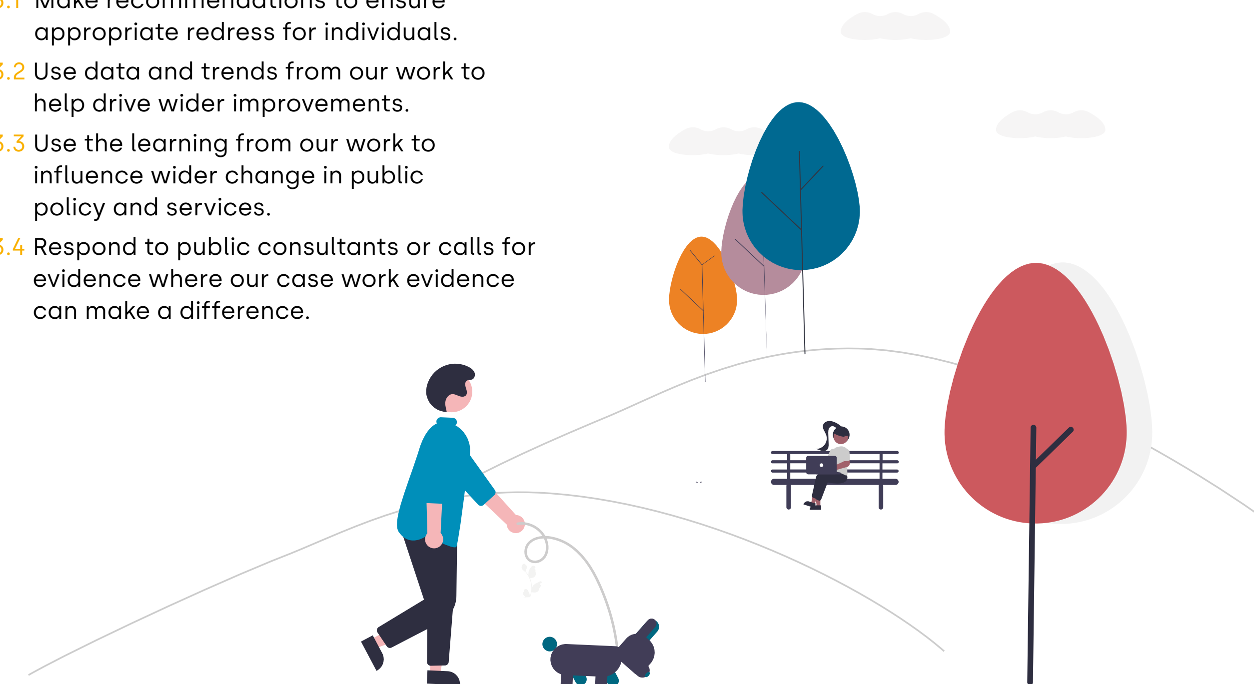
4.1 Invest in and develop our people to ensure that we provide a well-trained team across all functions as part of our new People Strategy.

4.2 Embed the principles of good administration and complaints handling into all our functions by providing independent service standards review and using peer review for continuous learning.

4.3 Deliver our statutory functions in line with our legislation.

Innovation and modernisation

5.1 Review and modernise our working systems and practices building on the move to digitisation that we have undertaken during the last two years.



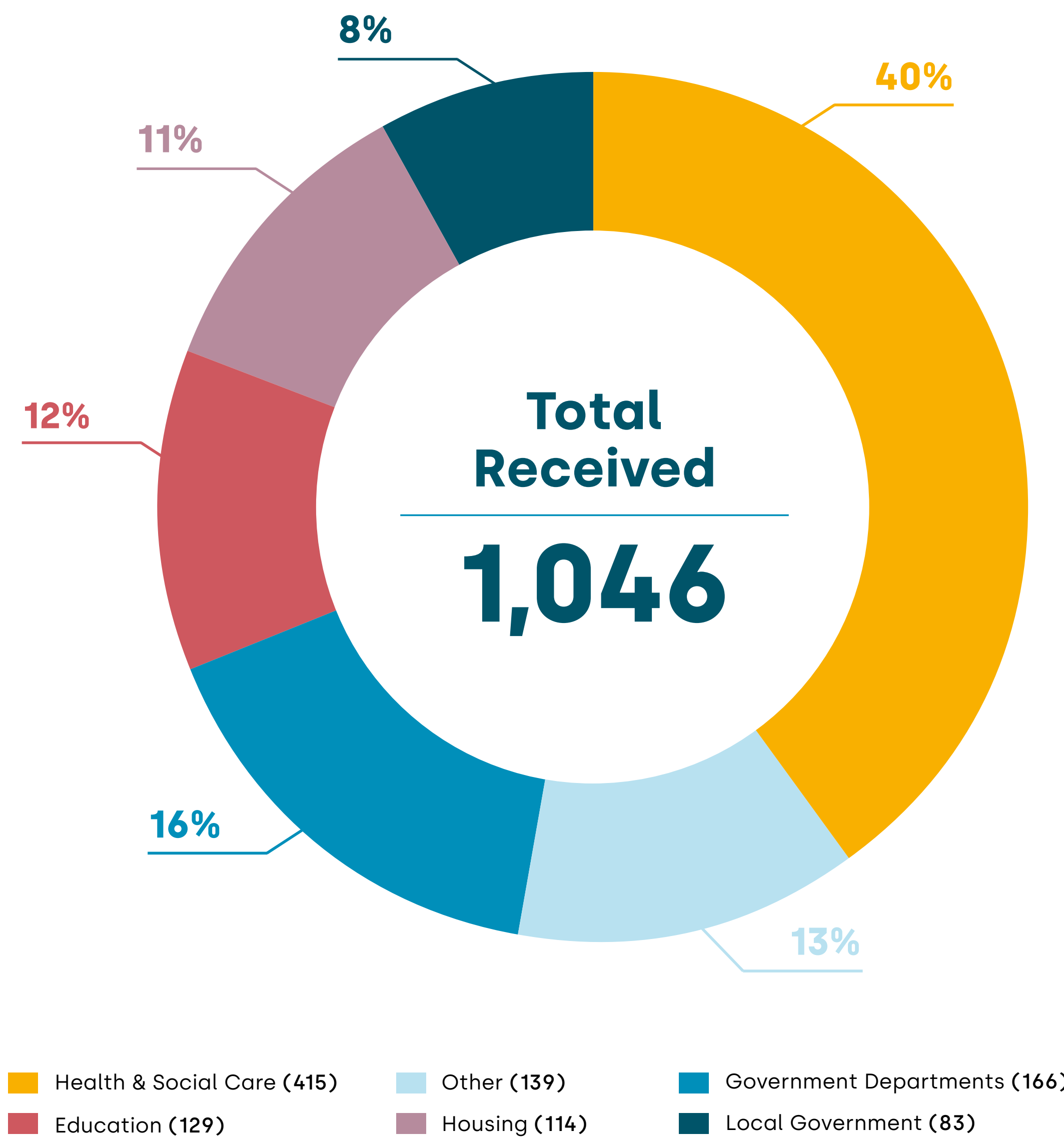
Section 1

Making a difference for individuals

We offer an alternative access to justice for those whose complaints to public bodies remain unresolved. We make a difference through investigating individual complaints and seeking to provide resolution and settlement where possible.

In 2022-23 reporting year we received 1,046 complaints.

Since our establishment in 2016 complaints about public services have gone up by 94%.



Health & Social Care (415) | Other (139) | Government Departments (166)
Education (129) | Housing (114) | Local Government (83)

Breakdown by Sector

Health and Social Care Trusts	311
Belfast Health & Social Care Trust	110
Northern Health & Social Care Trust	58
South Eastern Health & Social Care Trust	48
Western Health & Social Care Trust	47
Southern Health & Social Care Trust	39
SEHSCT - Prison Health Care	9

Other Health and Social Care	104
General Practitioners	56
Private Nursing and Care Homes	13
Dentists	11
Business Services Organisation	7
Independent Healthcare Providers	6
Out of Hours GP Services	3
Patient & Client Council	2
Regulation and Quality Improvement Authority	2
Pharmacists	1
Public Health Agency	1
Health & Social Care Board	1
Cwm Taf Morgannwg University Health Board (Wales)*	1

* investigation at the request of the Public Services Ombudsman for Wales

Government Departments & Agencies	166
Department for Communities	60
Driver & Vehicle Agency	26
Department of Finance - Land & Property Services	20
Department for Infrastructure	14
Department of Agriculture, Environment and Rural Affairs	9
Department for the Economy	7
Department of Health	5
Northern Ireland Courts & Tribunals Service	5
Department of Finance	3
The Executive Office	3
Appeals Service	2
Department of Education	2
Equality Commission for Northern Ireland	2
Legal Services Agency Northern Ireland	2
Northern Ireland Environment Agency	2
Arts Council	1
Charity Commission for Northern Ireland	1
Department for Infrastructure - Planning and Local Government Group	1
Department of Justice	1

Education	129
Primary Schools	36
Queen's University Belfast	31
Secondary Schools	21
Education Authority	20
Grammar Schools	9
Ulster University	4
Belfast Metropolitan College	2
Council for the Curriculum, Examinations & Assessment	2
Special Schools	2
College of Agriculture, Food & Rural Enterprise	1
Southern Regional College	1

Housing	114
Northern Ireland Housing Executive	77
Radius Housing	12
Clanmil Housing Association Ltd	8
Choice Housing	6
NB Housing	3
Triangle Housing Association Ltd	2
Apex Housing	1
Arbour Housing	1
Ark Housing Association (NI) Ltd	1
Connswater Homes Ltd	1
Others	2

Local Government	83
Lisburn & Castlereagh City Council	16
Newry, Mourne & Down District Council	14
Armagh City, Banbridge & Craigavon Borough Council	9
Belfast City Council	9
Ards & North Down Borough Council	7
Causeway Coast & Glens Borough Council	7
Mid & East Antrim Borough Council	7
Antrim & Newtownabbey Borough Council	4
Mid Ulster District Council	4
Derry City & Strabane District Council	3
Fermanagh & Omagh District Council	3

Case Summaries

We try and resolve complaints quickly, knowing that many people who come to NIPSO will have already been through a lengthy complaints process with the public body.

Almost all those who bring their complaints to us are looking for resolution and change. The earlier in our process we can achieve this the better. The vast majority of complaints are determined at our first investigation stage.

The cases below demonstrate some positive outcomes achieved from this first stage.

Case Summaries

CENTRAL GOVERNMENT

Man's complaint leads to broadband access

The complaint

A man complained that his home was not listed as eligible for broadband installation, despite all neighbouring properties qualifying.

This was because the Land and Property Services (LPS) "Pointer" database failed to register the property as built and occupied, which meant that the Department for the Economy had not added the complainant's property to the list.

How we helped

We asked the Department to check the issue with the company that installed the broadband. The company then arranged for the complainant's address to be included on the database, and the Department confirmed that the broadband service would be provided to the man's property without any additional costs. *(Ref. 202003897)*

CENTRAL GOVERNMENT

Driving test cancelled during Covid-19 pandemic

The complaint

A man said that during his driving test his face mask had caused his glasses to steam up. He asked the examiner if he could remove the mask so he could read a number plate, but as a result the examiner cancelled the test.

How we helped

After we spoke to the DVA it allowed the man to do the driving test again for free, allowing him to remove his face mask during the eyesight part. *(Ref. 202002908)*

HOUSING

Complaint about Housing Benefit advice

The complaint

A man said that he was repeatedly given a wrong figure by the Northern Ireland Housing Executive about how much Housing Benefit he would receive.

Although the Housing Executive accepted there had been a failure and apologised to him, the man did not feel this adequately reflected the distress caused.

How we helped

After we contacted the Housing Executive it offered the man a consolatory payment of £150. It gave him a further explanation of why the error occurred and set out the steps it had taken to ensure such an error did not occur in the future. It also confirmed that additional training was provided to the individual staff member and that general guidance would be issued to all staff.

HOUSING

Housing Executive compensates contractor for losses

The complaint

A contractor who works for the Northern Ireland Housing Executive (NIHE) said that a change in criteria meant he didn't get paid for works he had carried out.

How we helped

We found NIHE failed to inform contractors about the change in criteria and didn't detail the new requirements within the applicant packs. It agreed to compensate the contractor. *(Ref. 202000573)*

I am particularly grateful for the patience, empathy and discernment shown by [your staff] earlier today.

Complainant

EDUCATION

Student appealed university's decision not to accept her assignment

The complaint

A Queen's University student uploaded her assignment to the wrong part of an online system. The University told her to re-submit the assignment but the mark would be capped at 50%.

Unhappy with this outcome and the impact that it was having on her health, she approached our office.

How we helped

We talked to the University to get a resolution. In response the University said that it would mark the re-submitted assignment without applying a cap. *(Ref. 202002028)*

EDUCATION

Complaint about lack of parental consent

The complaint

A woman complained that the Education Authority (EA) arranged a meeting with her daughter's health professional without her consent. She also complained about how the EA handled her complaint.

How we helped

After we discussed the case with the EA it agreed to apologise to the parent. It also agreed to make service improvements to ensure that in future it asks parents before it approaches health professionals, and to make sure that clear records are kept when these requests are made. *(Ref. 202002242)*

Feedback

We encourage and welcome feedback from all those who contact us. Below are just some of the positive comments that complainants have provided.

I would like to thank you for your all your hard work in producing the report and for your professional and courteous manner during our telephone conversations.

I am particularly grateful for the patience, empathy and discernment shown by [your staff] earlier today.

I would like to express my gratitude and thanks for a flawless end-to-end service.

Thank you to the whole team that were involved in this. I feel seen and represented and I feel so glad that what I went through is being brought to light like this.

Always professional and well-informed, [the staff member] really made this difficult process more manageable and was a lifeline for my family in a time of crisis. She went above and beyond in her interaction with me and I cannot recommend her highly enough.

Keep doing what you are doing as you provide an excellent service.

Section 2

Making a difference through service improvement

As well as making a difference to individuals, our work has a positive impact on public services.

At the end of the investigation if we decide a public body did something wrong we will often ask them to apologise for what happened. We also make other recommendations to ensure that the public body learns from the complaint. For example we may recommend it provides staff training, or reviews its policies or procedures to prevent mistakes from happening again. We can also ask a public body to give someone any money they may be owed as a result of the maladministration.

If we can't resolve a case quickly because we need more information to help us make a decision, we will refer it for Further Investigation.

Recommendations from Further Investigation Reports - 2022/23	
Training or reminders to staff	117
Changes to policies or procedures	96
Apology	65
Payment	1
Systems/Processes	1
Other	2
Total	**282**

In 2022-23 we completed 67 Further Investigations.

We fully upheld 14 of these complaints, partially upheld 39, and did not uphold 14. This means that in almost 80% of cases the complaint was either fully or partially upheld.

The completed investigations included 282 recommendations, and made 78 requests for public bodies to show us evidence that the recommendations had been implemented.

Outcome of Further Investigations - 2022/23	
Complaint Not Upheld	14
Complaint Fully Upheld	14
Complaint Partially Upheld	39
Total	**67**

Impact of recommendations

The vast majority of those who bring a complaint to NIPSO give three reasons for doing so. They want to find out exactly what happened, they often want someone to say sorry, and they also want to ensure that what has happened to them does not happen to someone else. This is why the recommendations we make are particularly important and a critical element of improving public services. The cases outlined below demonstrate the range of cases and recommendations from the last year.

After we found that a hospital patient with learning disabilities was treated poorly (*ref: 201914662*), we said it would be a good idea for the Trust to appoint a special learning disability nurse who could be told whenever someone with a learning disability was admitted to hospital.

The Trust acted on this recommendation and appointed an Acute Liaison Nurse Learning Disability (ALNLD), a specialist nurse who trains staff caring for patients with learning disabilities. The nurse is also in charge of an online resource in the hospital which provides information to carers.

In another case (*ref. 201916096*) we asked clinicians to reflect on how they cared for a patient after her thyroid surgery, and asked them to provide evidence they had learned from the mistakes we found.

The clinicians realised that communication between the Endocrine Department and the Ear Nose and Throat (ENT) Department could be improved, so they created a new procedure to align the discharge letters for patients connected to both Endocrine and ENT services to help prevent missed follow-up requests and reduce other errors.

Another investigation into the treatment of a hospital patient (*ref. 201916053*) looked into whether a perforated bowel during a gallstone operation led to her death. After we criticised the quality of the record keeping the Trust sent reminders to staff on the importance of maintaining accurate notes to aid clinical decision making and to improve patient safety.

In a complaint about social care (*ref. 201915414*) we found that social workers should have made more detailed records of their interviews with a young person and done a better job of investigating a complaint. As a result they received training from the Trust on interviewing children and good complaints handling, and completed a further reflective piece on how they could improve their work.

We also asked a housing association (*ref.201917436*) to improve its record keeping after it failed to log a resident's concerns as Anti-Social Behaviour, even though they met the definition. It apologised to the complainant, carried out staff training on its Anti-Social Behaviour guidance, and showed us evidence of how it was handling concerns about Anti-Social Behaviour in the area.

Finally, a parent complained to us about how a primary school dealt with allegations of bullying, including how it recorded the incidents (*ref. 201911594*).

As a result of our investigation the school trained staff on its anti-bullying measures. It also reviewed its complaints handling policy and updated its policies and procedures to reflect good practice on risk assessments.

Further Investigation Case Summaries

CENTRAL GOVERNMENT

Man has thousands of pounds in benefits repaid after being wrongly told to apply for Universal Credit

Our investigation led to the Department for Communities repaying over £11,000 to a man after we found poor advice caused him to lose his existing benefits.

The man, a taxi driver, said he phoned the Employment Support Centre at the Department for Communities to make a claim for benefit because he was involved in a car accident and was temporarily unable to work.

He was already receiving Working Tax Credit at the time. He said that the adviser told him he should make a claim for Universal Credit, which he did straight after the call. However, he said he was not made aware that in doing so he would automatically lose his Working Tax Credit, even if his claim for Universal Credit was unsuccessful. When he was turned down for Universal Credit he said he was left worse off by £54 a week.

Our investigation looked to see whether the Department followed its own policies and guidance, either by referring the man to its own 'Make the Call' advice unit, to advice available online, to local independent advice services, or to the Independent Welfare Changes Helpline. The latter is a source of skilled, independent advice provided by Advice NI and funded by the Department in recognition of the complexity of welfare and tax credit changes.

We also asked for an audio recording of the conversation but discovered that although one was made at the time, it was subsequently destroyed. On the balance of the available evidence we concluded that the relevant guidance had not been followed and that the man had been treated unfairly.

To remedy the situation we asked the Department to make a payment to him equivalent to the Working Tax Credit he would have received, as well as provide him with an apology. His financial loss totalled £11,412.93.

We also recommended that the Department should improve the advice it gives to potential benefits claimants by making sure it gives details of other helplines which exist to help them with their claims.

Speaking about the case, Ombudsman Margaret Kelly welcomed the steps taken by the Department to prevent similar incidents from happening in the future, saying; *'The complainant in this case suffered a huge amount of stress and financial hardship through no fault of his own. I am pleased that following my investigation the Department have acknowledged he was treated unfairly, and put in place a number of measures to reduce the risk of other people going through the same experience.'* (*Ref. 201916360*)

Case Summaries

CENTRAL GOVERNMENT

Investigation finds Department failed to provide clear information over Covid-19 Business Support Scheme

A woman believed her business should have received financial support during the Covid-19 pandemic.

We asked the Department for the Economy to retrospectively accept and consider her application. *(Ref. 202001158)*

LOCAL GOVERNMENT

Investigation of a complaint against Belfast City Council

We found that a consultation response to a planning application should have been made available on the Planning Portal website.

While this was a record keeping error by the Belfast Planning Service, we found no grounds to question its decision to approve the application. *(Ref. 202000448)*

HEALTH AND SOCIAL CARE

Earlier treatment of man's eye condition may have improved his chances of recovery.

A Health Trust put in place new procedures for carrying out pre-operative assessments after we found that earlier surgery may have prevented a patient's loss of vision. *(Ref. 201916957)*

HEALTH AND SOCIAL CARE

Incidents in care home may have shortened mother's life

The Chief Executive of Conway Group Healthcare apologised to a resident's family after our investigation found serious failings in her care.

The resident's daughter complained to us about two separate incidents in The Cottage Care Home, Coleraine, which is owned by the Group. She said the care her mother received was 'seriously inadequate and totally unsatisfactory.' In one incident her mother fractured a leg while being moved by staff. In the other she said that the home failed to spot that her mother's dentures had become lodged in her throat.

Our investigation found that not enough care was taken while the resident was being helped to move from her bed to her chair and that her foot became caught in the bedrail.

Despite it being clear that the resident was in pain, staff continued with the manoeuvre. Once she was sitting down the staff checked for an injury, however this was not carried out properly and it wasn't until a day later that the fracture was found.

We also established that the resident didn't have an oral health care plan, and that when she experienced swallowing and breathing difficulties the home did not see that this could be related to her dentures having become displaced and lodged undetected in her throat for up to 24 hours.

Noting evidence which linked poor oral hygiene with aspiration pneumonia in elderly people, we concluded that the incidents caused the resident to suffer a significant degree of pain and discomfort.

Case Summaries

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: *"It is clear that the resident's daughter and her two brothers were devoted to their mother and very much involved in decisions regarding her care. The trauma and distress of losing her in the circumstances reflected in this report was evident in their correspondence to the home and to my Office.*

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.

Conway Group Healthcare accepted our recommendations. *(Ref. 201915712)*

HEALTH AND SOCIAL CARE

Patient's brain tumour wrongly diagnosed as viral headache

A Health Trust made a number of service improvements after we investigated a man's complaint that his wife's brain tumour should have been diagnosed earlier. *(Ref. 201914805)*

HEALTH AND SOCIAL CARE

Carer has respite fees refunded following complaint

A man said it was unfair that the Southern Health and Social Care Trust was taking money away from payments he received towards the cost of his daughter's respite care.

His daughter, who has complex medical needs, took short breaks either in property privately rented by him, or in the family home. The man paid for carers to look after her during these stays. He complained that as his daughter did not go to a residential home owned or arranged by the Trust, that it should not be deducting money from his direct payments as a contribution towards her care.

After discussing the situation with the Trust and looking at the information it provided, we found that it applied the contribution charges regardless of where the short break was taken. We believed that was not appropriate in this case.

We were satisfied that although the circumstances were unusual, the Trust did not have a policy or other guidance which covers where respite is taken outside of a residential or nursing home. We asked the Trust to correct this.

We also recommended that it stopped deducting the contribution charge from the payments to the man, and that it repaid the money taken so far. The Trust accepted our recommendations. *(Ref. 201914930)*

Case Summaries

HEALTH

Investigation into claim of Trust's failure to spot sepsis

We found that a patient who was showing signs of sepsis should have been referred to a senior clinician in Altnagelvin Hospital.

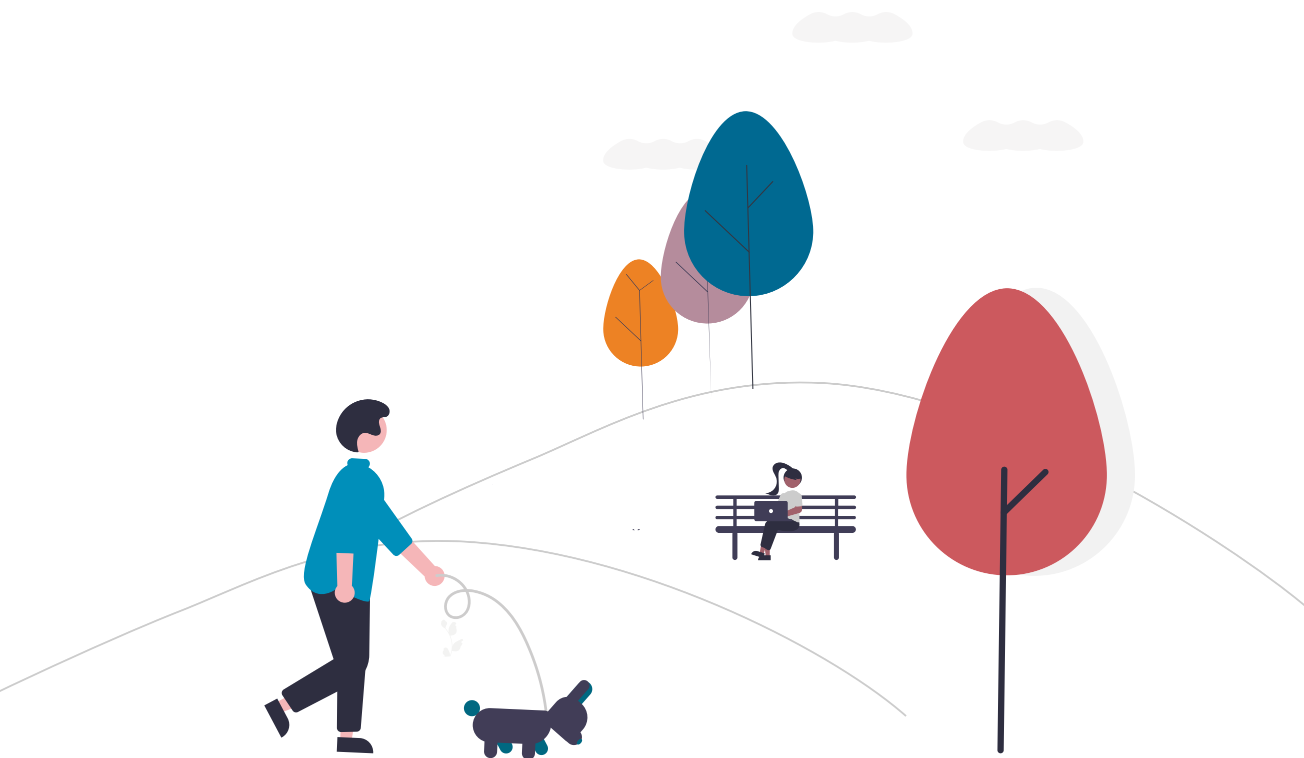
We asked for the Trust to apologise to the complainant, and for it to raise awareness of sepsis among junior doctors. *(Ref. 201916987)*

EDUCATION

University failed to explain findings of probe into bullying allegations

A student complained to Queen's University about bullying and harassment by other residents in her University accommodation.

Following our investigation the University apologised to the student for failures in the way it dealt with her complaint.
(Ref. 202000110)



Section 3

Making a difference through systemic change

Complaints standards

During the year we continued to develop our programme of improving complaints handling in public bodies.

In particular, within the local government sector we created networks with local councils and other organisations to hear what they thought worked well with the existing system and what suggestions they had to make the process better.

We created a Strategic Network, made up of senior local government officials responsible for creating the right culture for dealing with complaints, while our Operational Network consisted of staff responsible for working with the new complaints procedures.

Commenting before the first meeting of the Networks, Ombudsman Margaret Kelly stated:

"We know that making a complaint can sometimes be stressful and confusing. That is why we want public bodies to deal with complaints quickly and efficiently.

Specifically, we believe they should respond to straightforward complaints within five working days.

However, more complex complaints may progress to a second investigation stage. This stage should take the public body no more than 20 working days to complete, after which they should tell the complainant clearly the findings of the investigation and what further action they will be taking."

We're also creating training programmes to support the change in approach, including advice on how complaints should be investigated, and how to improve communication. They will explain how organisations should resolve complaints early in the complaints procedure and how to learn and improve from them.

The next sector for improving and standardising complaints handling is the health and social care sector. This is a complex and multi-faceted sector and we have already been engaging with many bodies to understand current approaches and develop a complaints standard approach that aims to put patients and complainants at the heart of the process.

Own Initiative

Our 'Own Initiative' function helps us make a difference in areas where we think there may be systemic failings.

In May 2022, we launched an investigation into the communications provided to patients placed on a healthcare waiting list. Having identified significant concerns about the lack of information patients receive at various stages of the process, we looked at guidance from the Department of Health and investigated the practices of the Health and Social Care Trusts.

We carried out two surveys, one to capture the experiences of patients and carers, and another to hear from General Practitioners (GPs) about the waiting list information provided by the Trusts.

We received a huge response, with 646 members of the public and 321 GPs taking part. We also heard directly from patients, their carers and GPs, carried out site visits, and made extensive information requests.

A draft report was shared with the Department and the Trusts at the end of March 2023, providing them with the opportunity to comment. The full report was published in June.

Pursuing improvement was also the focus of our follow up on our first 'Own Initiative' investigation into the administration of Personal Independence Payment (PIP). PIP is a benefit intended to provide help towards the extra costs arising from having a long-term health condition or disability.

In 2021, having found systemic failings, we made 33 detailed recommendations which centered on improving the gathering and use of 'further evidence' in the assessment process. In June 2022 the Department for Communities provided a written update on its action plan and throughout the year we obtained and tested evidence of implementation from both the Department and the Assessment Provider Capita.

The follow up report which detailed our assessment of the progress made was published in May 2023.

In July 2022, following concerns about the protection of trees within the planning system, we shared with the Department for Infrastructure and all eleven local councils our proposal to investigate the issue. We requested information from these public bodies and obtained data from other sources, allowing us to make a detailed analysis of the concerns during the year. We published our report in November 2023

Alongside these key areas of focus during 2022-2023 we have continued to identify and make enquiries on a range of other issues across public services to help inform our programme of work going forward and to drive systemic improvements.

Schools Case Digest

Undertaking an Own Initiative investigation is a thorough and painstaking process. It takes many hours of investigative resource and engagement and with a small team we are limited in how many we can undertake at any given time.

We also aim to have a thorough follow up approach to try to ensure the changes identified are implemented. This means that while there are many potential issues for Own Initiative investigation we cannot undertake them all.

However we have developed an approach of supporting improvement among public bodies by undertaking a Case Digest approach. This aims to pull together the cases we have received on a particular topic or issue and analyse the themes and trends to ensure public bodies can learn not just from their own complaints but those from similar organisations. During the year we produced a best practice guide for schools on how to deal with complaints.

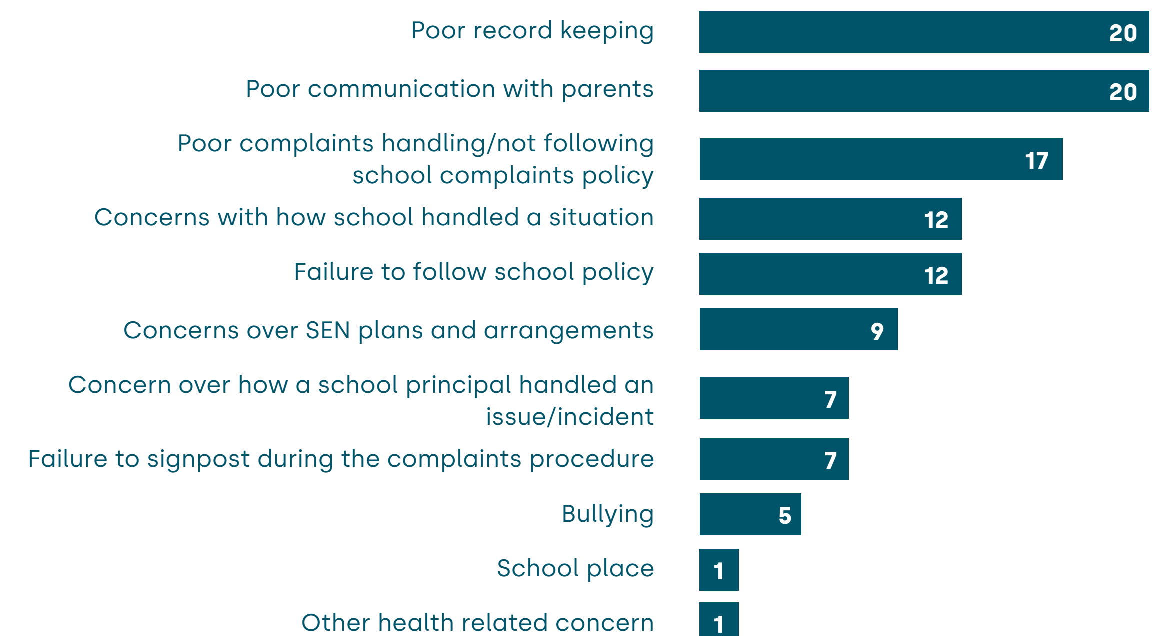
Through statistics and case summaries the Digest gives school leaders and Boards of Governors an insight into the most common areas of concern, and includes advice on how to investigate complaints.

Our analysis of the cases which underwent Further Investigation between 2017 and 2022 showed that the majority of investigations we carried out involved Primary Schools (16), with 5 investigations of cases involving Secondary Schools and 1 Special Education school.

Almost all had some element of poor record keeping and communication. Over three quarters involved a concern about how a complaint had been handled, or that it had not been handled in line with the school's own complaints policy.

Although making or receiving a complaint can be a difficult experience, the Digest shows it makes a real difference when complaints are genuinely treated as opportunities to listen, learn and improve.

Key themes of school complaints which reached full investigation between 2017 - June 2022



Engagement

Engagement is a key theme in our new strategic plan. We appointed an engagement and impact team to ensure we improve the knowledge and awareness of NIPSO and to reach out particularly to those groups and individuals we know are least likely to access NIPSO. During the year our Improvement, Engagement and Impact Team had over 50 meetings with representatives from the Community & Voluntary sector throughout Northern Ireland.

The aim of this engagement was to raise awareness and public understanding of the role of the Ombudsman and to encourage people to consider making a complaint when they experience a poor service.

The team met with groups working with children and families, people with a disability, asylum seekers and refugees, advice networks, women, rural communities, and LGBTQ+ people. NIPSO staff also engaged with the public at a range of public events including the Balmoral Show and Belfast Pride.

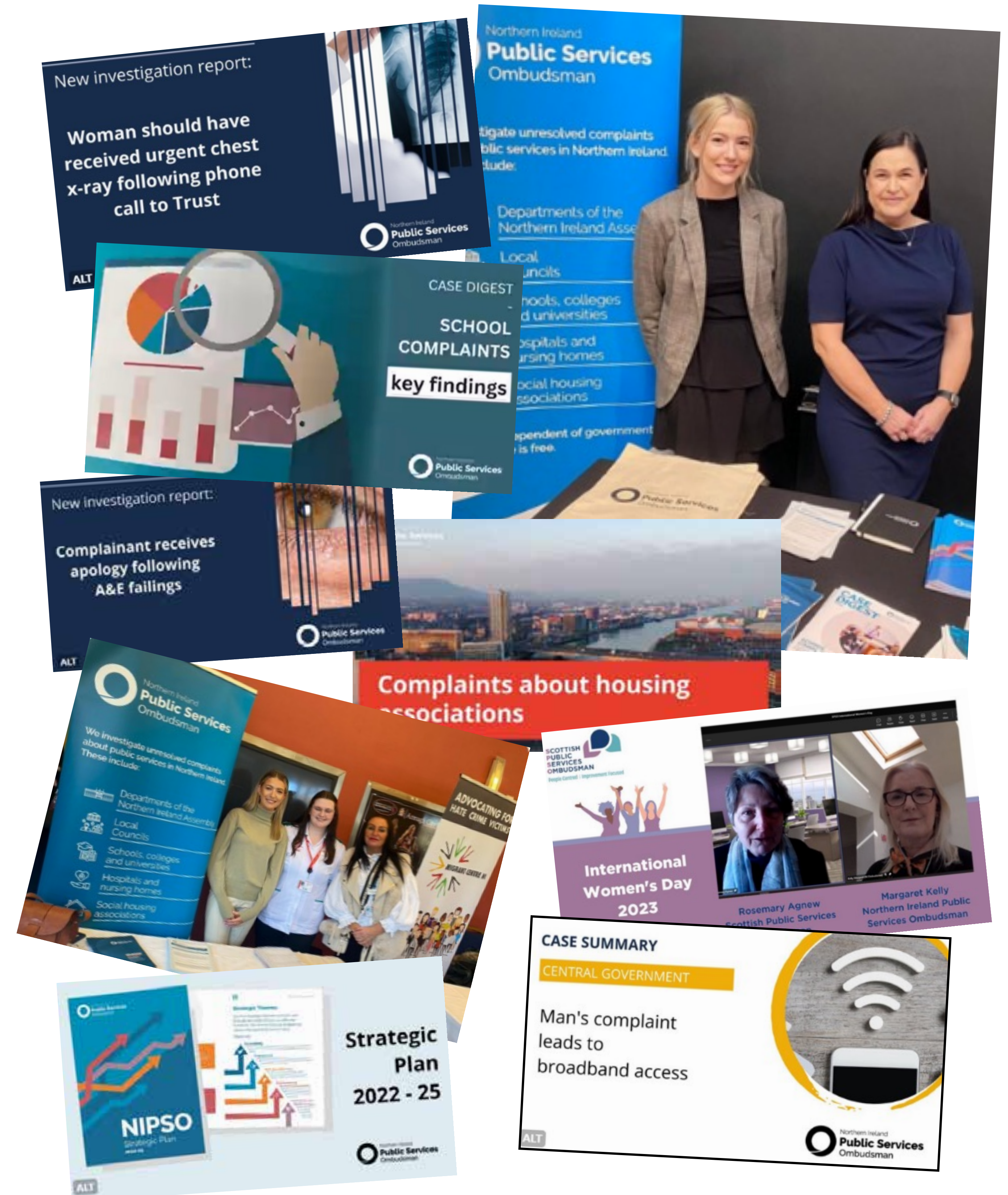
A key strategic aim of NIPSO is accessibility and inclusion, and a better understanding of the complainants who have used our Office can help us identify groups who are under-represented or those who may experience barriers. During 2022-23 we started a number of activities to develop our internal data analysis and data collection to progress this work.

Socio-economic status is frequently cited as a key determinant in the quality of public services experienced by individuals. To gain an insight into this issue we conducted a postcode analysis of complaints received in 2021-22 and 2022-23.

The data from these two years indicated that we received complaints in roughly equal numbers from each of the three main groups: 33% from the most deprived areas, 32% from mid-deprived areas, and 35% from the least deprived areas.

Data at this stage indicates a lower proportion of complaints from the 'most deprived' group about Trusts, schools, councils and nursing homes. We are also monitoring the proportion of complaints from 'most deprived' groups moving into investigation and further investigation. There is a higher likelihood of complaints from this group being closed at the Assessment stage and we want to better understand the reasons for this (for example, whether they are more likely to be out of jurisdiction or premature or whether there are other barriers we should be looking at).

As part of our Corporate Strategy commitment to impact and accessibility, the Team has also developed a survey to capture Equality, Diversity & Inclusion data from each new complainant from April 2023 onwards. It is hoped that over time, the results of this survey will help us understand the profile of people who bring complaints to us and importantly, help us identify whether there are people who are experiencing barriers to our organisation or the public bodies complaints processes. This information will also inform our engagement, communication and accessibility activity going forward.



Northern Ireland
Judicial Appointments
Ombudsman

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.

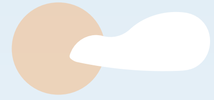
Following the devolution of policing and justice matters to the Northern Ireland Assembly in April 2010, such reports were laid by the Minister of Justice before the Assembly. However, the legislation governing the procedures for laying a report were amended by the Public Services Ombudsman Act (Northern Ireland) Act 2016 (the 2016 Act) to provide for the report to be laid before the Assembly by the Ombudsman.

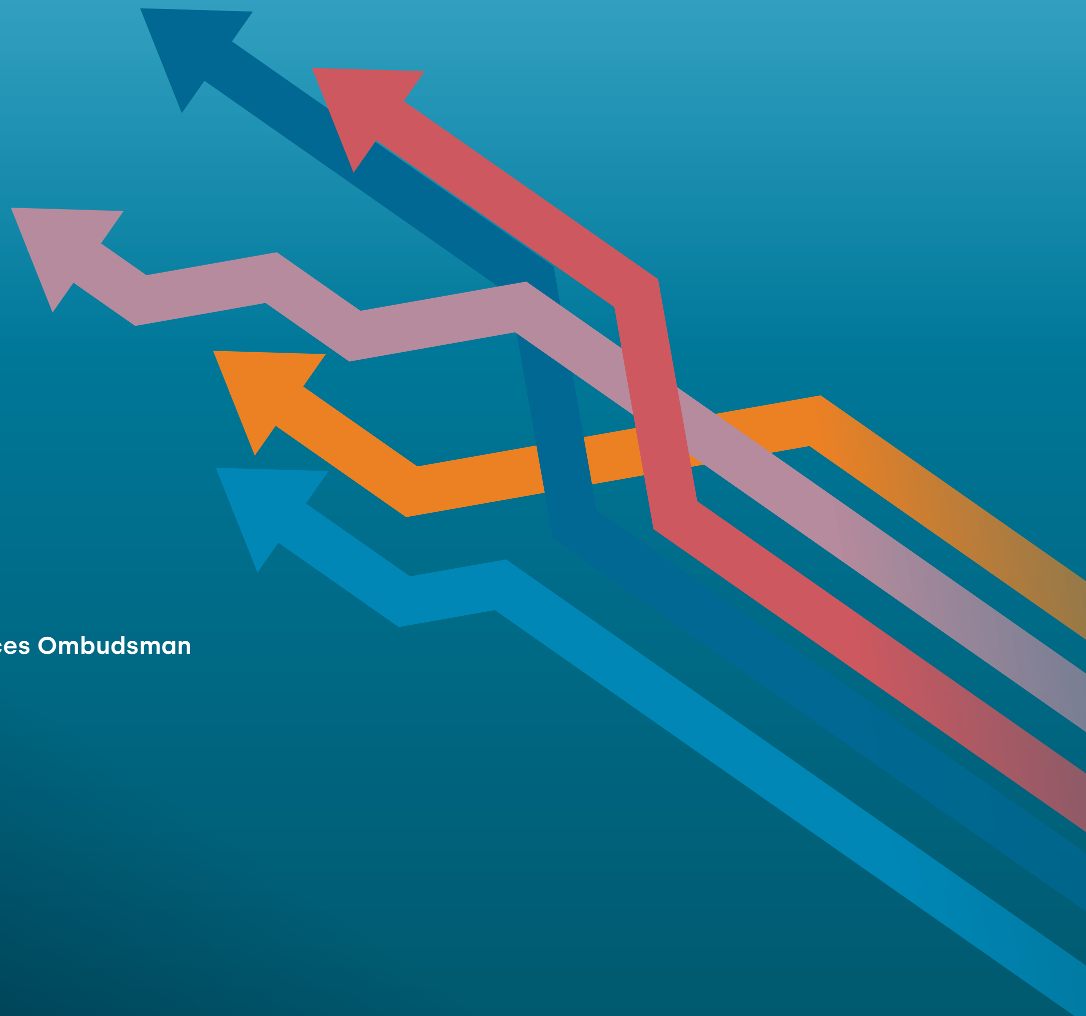
The statutory role of the Judicial Appointments Ombudsman is defined as a corporation sole and is independent of the Assembly, Government, the judiciary, NIJAC, the Northern Ireland Courts and Tribunals Service or the Department of Justice (Northern Ireland).

Complaint Activity

During 2022-23 the Judicial Appointments Ombudsman investigated one complaint.

Northern Ireland
Public Services
Ombudsman





GET IN TOUCH

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