Northern Ireland Ombudsman
Information Commissioner's Office

Good Administration and Good Records Management

The Eight Principles

Ombudsman Northern Ireland

ico. Information Commissioner's Office

Joint Foreword

I am pleased to present this publication which highlights the Principles of Good Administration and introduces new guidelines on Good Records Management. These principles are the framework by which I assess the actions of public bodies in my jurisdiction. They reflect the collective experience of 40 years of Ombudsmen in these islands when investigating complaints of service failure.

This initiative was launched to address the increasing failures I have identified in records management across the public sector in Northern Ireland. A record is defined as 'information created, received, and maintained as evidence and information by an organisation or person, in pursuance of legal obligations or in the transaction of business'. As this publication illustrates, failures in record management can have a devastating effect where a record is omitted or inaccessible, especially in a health or social care context.

With that in mind, I have developed principles revising previously stated principles and introducing two new records management based principles. I believe these eight principles capture the responsibilities of bodies in my jurisdiction. Illustrated with case studies, this publication provides a Back to Basics approach to records management. I have chosen a number of case studies to provide clarification for bodies in my jurisdiction on records management practice. I am pleased that the Information Commissioner's Office and ROI ombudsmen have provided additional case studies which help illustrate the importance of good records management. Other sources of useful guidance have been highlighted in this publication for the benefit of the reader and as specific reference tools for particular sectors.

I am grateful to the staff of PRONI for their assistance in the development of this publication. I am particularly grateful to the Information Commissioner for his contribution to this guide. I also extend my thanks to the English, Irish, Scottish and Welsh Ombudsmen for their assistance and permission to reproduce case summaries from their digests and annual reports to illustrate the importance of these principles. These case studies have been edited for the purposes of this publication.

I commend the publication and confirm that my office along with the Northern Ireland Office of the Information Commissioner will be actively promoting basic principles to ensure good administrative practices are embedded in public service across this jurisdiction.

Dr Tom Frawley CBE
Northern Ireland Ombudsman

Joint Foreword

Good administration and records management are an essential part of delivering high-quality public services. They are also vital to organisations meeting their statutory obligations under the Data Protection Act 1998 and the Freedom of Information Act 2000. So it is appropriate that the Northern Ireland Ombudsman and the Information Commissioner have worked together to produce this publication for public authorities.

As the Ombudsman rightly points out, failures in records management can have a devastating effect on service users, particularly within a health or social care context. For the individuals affected by those errors, timely provision of accurate and relevant information relating to

their cases becomes crucial to their understanding of what may have gone wrong and why. It is therefore important that their rights of access to information are properly upheld. Breaches of those rights may add significantly to the anxiety experienced by people who already may be undergoing substantial levels of stress as a consequence of poor service delivery.

Application of the Principles of Good Administration and Good Records Management will help organisations address the too numerous failures by public authorities which both the Ombudsman and I have identified from complaints made to us by members of the public. These failures are illustrated within case studies from our offices and those of colleagues in England, Ireland, Scotland and Wales. My office in Northern Ireland will now work with the Ombudsman's Office to promote the adoption of the Principles by organisations and thus improve practice in record handling throughout the jurisdiction.

Christopher Graham
Information Commissioner

The Principles and Case Study Illustrations

Contents

Principle 1

Get it right

This can be achieved by:

(i) Acting in accordance with the law and with due regard for the rights of those concerned.

Public bodies should:

a. comply with the law and have regard for the rights of those concerned

b. act according to their statutory powers and duties and any other rules governing the service they provide

c. follow their own policy and procedural guidance, whether published or internal

d. use their powers only for the specific purpose for which they are given

e. apply their powers with objectivity and impartiality

f. disregard factors which are not relevant to a particular case

(ii) Acting in accordance with the public body's policy and guidance.

Public bodies should:

a. act in accordance with relevant codes of practice, government circulars and established good practice

b. ensure that decision making criteria are clear and relevant and can be applied objectively so that decisions have not been made on an inconsistent, ad hoc or subjective basis

c. ensure that records created comply with the relevant statutory and legislative environment in which the Public Body operates. They should comply with any record keeping requirements resulting from legislation, audit rules and other legislation

(iii) Taking proper account of established good practice.

Public bodies should:

a. take proper account of recognised quality standards, established good practice and their own guidance

b. record the reason(s) when they decide to depart from these standards

(iv) Providing effective services, using appropriately trained and competent staff.

Public bodies should:

a. provide effective services with appropriately trained and competent staff who understand and fulfill the legal requirements relevant to their area of activity

b. plan carefully when introducing new policies and procedures

c. plan and prioritise their resources to meet their statutory duties, published service standards or both

The following Information Commissioner's Office case study illustrates the need to comply with the law on data protection and the importance of getting it right in relation to personal data.

Case Study

The Northern Health and Social Care Trust

A number of security incidents relating to personal sensitive data had taken place within the Trust, including a fax being sent in error from Antrim Hospital to a local business and minutes of a meeting being shared inappropriately with professionals working in partnership with the Trust. The Information Commissioner's Office completed an investigation into compliance with the Data Protection Act and established that

although policies and procedures were in place including mandatory Information Governance training for all staff, the take-up of training was not being properly monitored and recorded and it had not been completed by all staff. The Information Commissioner issued an Enforcement Notice on the Trust requiring a number of measures to be put in place to ensure that staff attended the mandatory training. In addition, the Trust agreed to an audit being completed by the Information Commissioner's Office.

(v) Making decisions which are reasonable and timely, and which have been based on all relevant considerations.

Public bodies should:

a. have regard to the relevant legislation in their decision making

b. take account of all relevant considerations, ignore irrelevant ones and balance the evidence appropriately when making decisions

c. ensure that discretionary powers are exercised in a reasonable manner

d. spend public money with care and propriety

e. operate fairly and reasonably when assessing risk

Case Studies

The following two cases, decided by the Northern Ireland Ombudsman, illustrate the importance of addressing all relevant considerations in decision making, but also in ensuring proper records of interactions between members of the public and public bodies are retained.

This complaint about the Rivers Agency illustrates how decision making should take account of all relevant considerations, ignore irrelevant ones and balance the evidence.

Rivers Agency: Failure to take action in response to report of flooding

Alteration works undertaken by Roads Service had caused water logging on the complainant's land. Roads Service began to liaise with the Rivers Agency in order to resolve his complaint. The Northern Ireland Ombudsman found that

the Rivers Agency had indicated on a number of occasions over a period of four and a half years that it would take action. Subsequently Rivers Agency decided not to take any corrective action and this was found to be maladministration as the decision had not been informed by all relevant considerations. Further, there was avoidable delay and a failure to keep proper records of meetings and site visits. The Ombudsman recommendations for an apology and financial redress of £3000 were met by the Agency.

Northern Ireland Ombudsman, Annual Report of the Assembly Ombudsman for Northern Ireland and the Northern Ireland Commissioner for Complaints, 2011-2012

The investigation into a health related complaint below highlights the importance of good record keeping, and the need to address all issues of complaint when assessing those complaints.

Western Health and Social Services Board (WHSSB) – Medical records did not provide sufficient evidence

The Northern Ireland Convenor of the WHSSB had declined to independently review a complaint made about a general practitioners (GP) care and treatment of the complainant's late daughter. The complainant was concerned that his daughter's medical notes omitted important details in relation to the nature of the chest pain that his daughter had experienced. Clinical advice obtained by the Northern Ireland Ombudsman emphasised the importance of full and accurate recording of the presenting features of new chest pain in patients.

The Ombudsman found that the medical record for the patient's consultation with her GP did not provide sufficient evidential basis for the clinical adviser to state that the symptoms displayed by the complainant's daughter were suggestive of dyspepsia and acid reflux, neither could it be concluded that appropriate investigation and treatment was arranged at that time.

Also, the Ombudsman found failings on the part of the Convenor in addressing each of the issues raised by the complainant. An apology was recommended.

Northern Ireland Ombudsman, Annual Report of the Assembly Ombudsman for Northern Ireland and the Northern Ireland Commissioner for Complaints, 2010-2011

Principle 2

Focus on the customer

This can be achieved by:

(i) Ensuring people can access services easily, including those with a disability or special needs.

Public bodies should:

a. provide services and information that are easily accessible to their customers

b. have policies and procedures which are clear

c. provide accurate, complete and understandable information about their services (Under section 16 of the Freedom of Information Act 2000 there is a requirement on public bodies to publish the rules, procedures, practices, guidelines and interpretations used by the body, and an index of any precedents kept by the body, for the purposes of decisions, determinations or recommendations)

d. communicate effectively, using language that people can understand and that is appropriate to them and their circumstances

(ii) Informing customers what they can expect and what the public body expects of them.

Public bodies should:

a. inform customers about their entitlements

b. ensure that clients understand what they can and cannot expect from the organisation

c. ensure that customers understand their own responsibilities

(iii) Keeping to commitments, including any published service standards.

Public bodies should:

a. do what they say they are going to do

b. keep a commitment or explain why they cannot, if that is the case

c. meet their published service standards, or let customers know if they cannot

(iv) Dealing with people helpfully, promptly and sensitively, bearing in mind their particular individual circumstances.

Public bodies should:

d. behave helpfully, dealing with people promptly, within reasonable timescales and within any published time limits (Under the Ombudsman Amendment Act 2012 there is an obligation on public bodies to give reasonable assistance and guidance to people, and provide information to people on any rights of appeal or review)

e. avoid undue delay

f. tell people if things may take longer than originally stated

g. treat people with sensitivity, bearing in mind their individual needs

h. respond flexibly to the circumstances of a case, by having regard to the individual's age, to their capacity to understand often complex rules, to any disability they may have and to their feelings, their privacy and convenience

(v) Responding to customers' needs flexibly including, where appropriate, co-ordinating a response with other service providers.

Public bodies should:

a. where appropriate, deal with customers in a co-ordinated way with other service providers to ensure their needs are met

b. refer them to any other sources of assistance, if they are unable to help

Case Studies

The following two cases, decided by the Northern Ireland Ombudsman, illustrate the importance of having appropriate policies in place with a focus on responsibility to customers, employees and, where appropriate, the general public.

While Ombudsmen will not scrutinise comment on how policy should be framed, they may find maladministration for failure to have an appropriate policy in place, as in the following case involving the Western Education and Library Board.

Western Education and Library Board – Lack of procedure for complaints about the actions of non-board co-workers

This case concerned a complaint from an employee of the Board regarding its response to a complaint she had made about the actions of non-Board co-workers. The complainant was unhappy with the way in which the Board addressed her concerns, which she had reported to it on a number of occasions. The Board asserted that it was unable to investigate her complaint because it was not the employer of the individuals who were the focus of her complaint.

The Ombudsman found that the Board failed to deal appropriately with the complainant's grievance. Significantly, the Board had no policy or procedure in place to address complaints from its staff about non-Board employees.

While the Ombudsman acknowledged that the Board did take some steps to deal with its employee's grievance, he found that the lack of a specific procedure, denied the complainant the opportunity to have her

concerns addressed in a timely, thorough and impartial way. A written apology to her and a consolatory payment of £2,000 was recommended to address this.

Northern Ireland Ombudsman, Annual Report of the Assembly Ombudsman for Northern Ireland and the Northern Ireland Commissioner for Complaints, 2010-2011

Where there is an existing policy and it is not implemented, this may constitute maladministration. The case below, involving Craigavon Borough Council, illustrates this and the importance of recording fully and explicitly the methodology of any actions taken to implement a policy.

Craigavon Borough Council - Failure to follow policy and procedures

The complainant had initiated a grievance against another employee of Craigavon Borough Council on the basis of what he believed was an unfounded allegation. The Council's subsequent investigation and report stated that there was sufficient evidence to support his claim. The employee who was the subject of the grievance successfully appealed because there was an inappropriate process and the original conclusions and recommendations of the investigation were set aside. In notifying the complainant of this, the Council stated that the appeal had been conducted under stage 4 of its former grievance policy and the matter was considered closed. The complainant was unhappy with the Council's apparent failure to follow its policy and appropriate procedures in his case.

The Ombudsman found several instances of maladministration by the Council, including 'process deficiencies'; a failure by the Council to record explicitly the methodology; and confusion as to the precise stage of the Council's grievance procedure under which the appeal was heard. The Council subsequently introduced and implemented a revised grievance policy, and committed to introduce a range of measures to ensure no recurrence of the failures in addition to other remedies.

Northern Ireland Ombudsman, Annual Report of the Assembly Ombudsman for Northern Ireland and the Northern Ireland Commissioner for Complaints, 2011-2012

Principle 3

Be open and accountable

This can be achieved by:

(i) Being open and clear about policies and procedures, and ensuring that information and any advice provided is clear, accurate and complete.

Public bodies should:

a. handle information as openly and transparently as the law allows

b. give people information and, if appropriate, advice. This should be clear, accurate, complete, relevant and timely

c. ensure that people know what information is available, where to get it and how to access it in accordance with the Freedom of Information Act 2000 and otherwise

d. simplify procedures, forms and information on entitlements and services

e. provide clear and precise details on time limits or conditions which might result in customer penalties or disqualification

(ii) Stating the criteria for decision making and giving reasons for decisions.

Public bodies should:

a. state their criteria for decision making and give full reasons to their customers for their decisions, particularly for a decision which adversely affects them (this is a legal requirement under the Freedom of Information Act 2000)

b. be open and truthful when accounting for their decisions and actions

c. ensure that, where a service is based on a scheme of priorities, that the scheme is open and transparent

(iii) Handling information properly and appropriately.

Public bodies should:

a. handle and process information properly and appropriately in line with the law

b. respect the privacy of personal and confidential information, as the law requires (See the provisions of the Data Protection Act 1998 for example). Inappropriate disclosure of sensitive information, or of information given in confidence, can cause at the very least, reputational damage

The following Information Commissioner's Office case study illustrates the need for accurate personal information

Case Study

Halton Borough Council

A clerical officer in the Council's administrative shared service sent a letter from the adoptive parents to the birth mother about her child's progress under a post-adoption agreement.

The officer also mistakenly sent the birth mother a covering letter which showed the adoptive parents' home address. This information was passed to the birth mother's parents who then wrote to the adoptive parents seeking contact. An application to the Court for direct contact by these grandparents was subsequently refused. Because of the administrative error, the Information Commissioner issued the Council with a civil monetary fine of £70,000. A clear checklist of requirements before these letters are distributed, together with a quality checking process has been developed by the Council.

(iv) Taking responsibility for your actions.

Public bodies should:

a. take responsibility for the administrative and business related actions of their staff.

Case Studies

The following cases illustrate the importance of handling information properly and maintaining confidentiality when required to do so. The first case investigated by the Parliamentary and Health Service Ombudsman highlights the need to keep witness statements 'confidential' in fraud investigations due to the risk of retaliation and the impact on individuals when confidentiality is breached.

JobCentre Plus: Breach of confidentiality - a mistake that cost one woman her home

Mrs J made a witness statement during a fraud investigation that Jobcentre Plus and the local authority were pursuing into one of her neighbours. Despite commitments to the contrary, Jobcentre Plus failed to keep her statement or, most importantly, her identity, confidential.

Mrs J was then threatened and had stones thrown at her windows; she was followed and her children were bullied at school. Her children changed schools at great inconvenience and had to commute for two hours a day as a result.

Mrs J's mental health declined and she described her experience as one of 'living in fear, hell and anxiety'.

Mrs J complained to Jobcentre Plus and, although they took her complaint seriously and paid her £750 in compensation, they told her they were not responsible for her neighbour's actions and advised contact with the police.

Mrs J saw no option but to move home, she was frightened for her own safety and for that of her children. Mrs J said she was 'ashamed and angry about having signed the statement and would never do it again…'

The Ombudsman upheld the complaint and found it was for Jobcentre Plus to return Mrs J to a position where she could

continue normal life which, in the circumstances, had to be in a new home. The Ombudsman recommended that Jobcentre Plus work with the local Council to ensure Mrs J was rehoused, and recommended that a payment to cover Mrs J's relocation costs. In addition, the Ombudsman recommended £6,000 be paid in recognition of the impact the actions of Jobcentre Plus had on Mrs J and her children.

Parliamentary and Health Service Ombudsman, Responsive and Accountable?: The Ombudsman's review of complaint handling by government departments and public bodies, 2010-2011

In the following investigation by the Irish Ombudsman, the need for decisions to be clear and openly expressed is highlighted.

Laois County Council: Council revises procedures for housing transfer requests following intervention by the Ombudsman

A woman was turned down for a housing transfer by Laois County Council. The woman had sought a transfer following serious social problems and a fire in her Council accommodation. The Council had turned down her request on the grounds that all transfers had been suspended due to financial constraints except in 'exceptional medical or social circumstances'.

On examination of the Council's documentation on the case, the Ombudsman was concerned about its administration of the transfer application. There appeared to be no evidence in the Council's files to show that it had considered whether exceptional medical or social circumstances applied. Further, the Council's assessment of the application was not properly documented. The Ombudsman invited the Council to review its procedures and to invite the complainant to formally apply for a transfer.

Following a further assessment, the Council placed the complainant on its housing transfer list and the complainant was offered and accepted a transfer. The Council also reviewed its procedures relating to transfer requests.

The Office of the Ombudsman, Annual Report, 2012

Principle 4

Act fairly and proportionately

This can be achieved by:

(i) Treating people impartially, with respect and courtesy.

Public bodies should:

b. deal with people fairly and with respect

c. be prepared to listen to their customers

d. avoid being defensive when things go wrong

e. understand and respect the diversity of their customers

f. ensure equal access to services and treatment regardless of background or circumstance

(ii) Avoiding unfair discrimination or prejudice, and ensuring no conflict of interests.

Public bodies should:

a. ensure that actions and decisions are free from any personal bias or interests that could prejudice those actions and decisions

b. declare any conflict of interest

c. not act in a way that unlawfully discriminates against or unjustifiably favours particular individuals or interests

(iii) Dealing with people and issues objectively and consistently.

Public bodies should:

a. treat people fairly and consistently, so that those in similar circumstances are dealt with in a similar way

b. justify any difference in treatment by the individual circumstances of the case

(iv) Ensuring that decisions and actions are proportionate, appropriate and fair.

Public bodies should:

a. behave reasonably when taking decisions, particularly when imposing penalties

b. ensure that the measures taken are proportionate to the objectives being pursued, appropriate in the circumstances and fair to the individuals concerned avoid penalties which are out of proportion to what is necessary to ensure compliance with the rules

c. be able to rely on the records made or created in support of those decisions. There should be no doubt as to the record's authenticity as evidence of the past and for use in the future

(v) Ensuring that rules are applied equitably.

Public bodies should:

a. avoid penalties which are out of proportion to what is necessary to ensure compliance with the rules

b. accept that rules and regulations, while important in ensuring fairness, should not be applied so rigidly or inflexibly as to create an inequity

c. address any unfairness, if, in applying (a) the law, (b) regulations or (c) procedures strictly would lead to an unfair result for an individual

d. bear in mind the proper protection of public funds

e. ensure they do not exceed their legal powers

Case Studies

The importance of treating people fairly is highlighted in the following complaint investigated by the Northern Ireland Ombudsman where the owner of a taxi business was unfairly excluded from a tender.

Northern Health & Social Care Trust: Unfair exclusion from tender process

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

The Ombudsman found that the Trust's preferred means of determining whether a bidder was financially viable was by reference to a company which compiled statistical business information. However, this method was only possible if the bidder was registered with that company. Where a bidder was not registered, the Trust (in order to be inclusive) determined whether the financial viability prerequisite had been met by scrutinising the bidder's accounts.

With regard to 'registered' bidders, the Ombudsman found that the Trust determined that those bidders who were deemed (from the statistical analysis) to have "a high risk of business failure" would in any event be considered to be financially viable for the purposes of the tender. The complainant's competitor fell into this category.

The investigation concluded that the complainant had been unfairly excluded from the tender. The Ombudsman found this was maladministration and that had the complainant not been excluded, his tender would have been successful. That being so I found that the complainant experienced an injustice.

The Trust accepted the Ombudsman's recommendations for an apology and payment of £2,500.

A public body must treat people properly and fairly and this is highlighted in the Parliamentary Ombudsman's case below.

UK Border Agency: Mishandling of information and records in relation to a residence card application

Mrs N (a Romanian national) applied for a residence card on the basis that she was the spouse of a Dutch national employed in the UK. The UK Border Agency wrote to ask Mrs N for evidence that her husband was still employed in the UK.

Mrs N's application for a residence card was subject to a catalogue of errors by the Agency. They wrote to her at the wrong address, failed to identify a letter as an appeal, and incorrectly sent her file to the removals unit, where it was wrongly put into storage.

They also failed to respond to the substance of Mrs N's complaint about their handling of her case and so missed the opportunity to put right their earlier mistakes. The Ombudsman found that these errors amounted to maladministration and upheld her complaint. The Agency accepted that it was likely that Mrs N would have supplied the information they had asked for originally and were satisfied that she would have qualified for the residence card at that time. The Agency apologised, made a payment of £300 and took a decision on her residence card application, which they subsequently approved.

Parliamentary and Health Service Ombudsman, 'Fast and Fair? A report by the Parliamentary Ombudsman on the UK Border Agency', 2009-2010

Principle 5

Putting things right

This can be achieved by:

(i) Acknowledging errors and correcting mistakes quickly and effectively.

Public bodies should:

a. acknowledge when mistakes have happened, apologise, and explain what went wrong

b. correct any decisions found to be incorrect, as supported by records used or created in the course of making those decisions

c. review and amend any policies and procedures found to be ineffective, unworkable or unfair

d. give appropriate notice before changing rules, particularly where a person's entitlement might be adversely affected

(ii) Providing clear and timely information on how and when to appeal or complain.

Public bodies should:

a. provide clear and timely information about methods by which people can appeal or complain (Under the

Ombudsman Acts there is a duty on public bodies to provide information to people on any rights of appeal or review)

b. provide information about appropriate organisational or independent ways of resolving complaints

c. consider providing information about possible sources of help for the customer, particularly for people who may find the complaints process daunting

(iii) Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

Public bodies should:

a. operate effective complaints procedures which investigate complaints thoroughly, quickly, impartially and meet the principles of fair procedure and natural justice

b. have an internal review system so that decisions can be looked at again and reviewed by someone not involved in the first decision

c. provide an appropriate range of remedies to the complainant and any others similarly affected when a complaint is upheld. The remedy offered should seek to put the complainant back in the position they would have been in if nothing had gone wrong. Where this is not possible, as will sometimes be the case, the remedy offered should fairly reflect the harm the complainant has suffered.

d. Public bodies should adopt a policy for dealing with the small number of people who act in a vexatious manner or in bad faith, which strikes a balance between the interests of the public body, its staff and the person concerned.

Case Studies

Ombudsmen investigate complaints from individuals but can make recommendations for systemic change to improve public administration. The following two cases, illustrate that when public administration or public service fails, it is important to have an effective complaints procedure. This enables bodies to learn from their mistakes and put things right for the benefit of all citizens.

In the case below, involving Land Registers of Northern Ireland, the Ombudsman was critical of the fact that the person who was the subject of the complaint was asked to investigate and respond to it.

Land Registers of Northern Ireland (LRNI): Loss of registered documents and failure in document retrieval process

The complainant made repeated requests to LRNI over a nine month period, for 'two important legal documents' which were required for a land dispute. The substance of the complaint was that the documents had been lost 'without trace', and how LRNI subsequently handled representations made by the complainant made using LRNI's Internal Complaints process.

However, only when the Ombudsman commenced an investigation were the missing documents found. The Ombudsman's investigation revealed failings in LRNI's document retrieval process which resulted in a failure to track the movement of registered documents between its offices in Belfast and its off-site archive.

The Ombudsman's investigation found a number of instances of maladministration by LRNI in the form of delays and a failure to keep the complainant regularly informed of its efforts to locate the documents she required. In addition the Ombudsman was critical of the fact that a member of staff against whom part of the complainant's grievance was directed, was subsequently given responsibility to investigate and respond to it. The Ombudsman considered that an independent examination of the complaint by LRNI, at a senior level, would have been required.

In this case the remedy recommended was an apology and

a payment of £3,000, together with reimbursement of legal costs incurred, all of which were met.

Northern Ireland Ombudsman, Annual Report of the Assembly Ombudsman for Northern Ireland and the Northern Ireland Commissioner for Complaints, 2007-2008

In the case below, the Ombudsman identified shortcomings in the way that Fife Council dealt with a complaint relating to changes in planning consent.

Fife Council: Failure in handling changes to a planning proposal

Mr C submitted a complaint to the Ombudsman regarding changes to proposals for planning consent for a superstore to the rear of his home. Mr C's complaint related to the location of a large sprinkler tank which was now sited immediately adjacent to his boundary; the proximity of the water sprinkler tank to his boundary fence; and the light and noise pollution arising from the service area of the superstore. Mr C complained about Fife Council's handling of the changes and correspondence on the matter.

The Ombudsman found that the Council had failed in their assessment of an initial application and decision on material variations, to demonstrate that consideration was given to materiality of the changes and whether further neighbour notification should be carried out. It was also found that in the council's assessment of a second application failed to consider whether a report on environmental issues remained valid, the effect the changes would have on Mr C's property, whether the application was properly described and whether the sprinkler tank complied with Council policy and design guidance. The Ombudsman also upheld Mr C's complaint with regards to the delay and failure to reply to correspondence.

The Ombudsman recommended that the Council apologise to Mr C for the identified shortcomings in dealing with his correspondence and complaint and for the inadequacies in record-keeping; and assess whether there are in fact any noise problems emanating from the plant buildings, and if so, approach the superstore company. The Council accepted the recommendations put forward by the Ombudsman.

Scottish Public Services Ombudsman: Compendium of Case Reports for March 2012

Principle 6

Strive for improvement

This can be achieved by:

(i) Reviewing policies and procedures regularly to ensure they are effective.

Public bodies should:

review their policies to ensure they are effective and relevant.

(ii) Asking for feedback and using it to improve services and performance.

Public bodies should:

actively seek and welcome all feedback, both compliments and complaints.

(iii) Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

Public bodies should:

learn from feedback to improve service delivery and performance. Follow-up guidance to staff should also be provided.

Case Studies

The following two case studies, decided by the Northern Ireland Ombudsman, illustrate that public bodies should strive for improvements, reviewing policies and procedures regularly and ensuring lessons are learnt from complaints.

The failure by the Southern Health and Social Care Trust to ensure staff followed procedures which had been implemented to address previously identified deficiencies is highlighted by the case below.

Southern Health & Social Care Trust: Failures in patient care and treatment and poor quality nursing records

This complaint concerned the diagnosis, care, treatment and decision to discharge provided to the complainant's late husband by the Trust. At her husband's admission, the A&E doctor should in her view have had results of previous investigations. She was unhappy with the nursing care provided to her husband in terms of personal hygiene care; collection of stool sample; record of weight; wound care; and quality of nursing notes. The complainant also questioned the Trust's information regarding his acquisition of Clostridium difficile infection.

The Ombudsman found there was evidence that the Trust's nursing care was not of a reasonable standard in relation to personal hygiene care and the collection of stool samples. The Ombudsman noted that the Trust had acknowledged these failings at local resolution stage but he also found maladministration in the Trust's recording of the patient's weight, his wound care and the quality of nursing notes. The Trust advised that it had introduced a series of initiatives to address the identified failings although procedures had previously been in place to avoid these failings but were not followed. The Trust provided the complainant with an apology and a payment of £1,000 because of the injustice caused by these failings. Other aspects of the complaint were not upheld.

Northern Ireland Ombudsman, Annual Report of the Assembly Ombudsman for Northern Ireland and the Northern Ireland Commissioner for Complaints, 2012-2013

As a result of an Ombudsman investigation, improvements in public administration can be achieved. The following case relates to a complaint about the Northern Ireland Housing Executive which, as a result of the Ombudsman's intervention, resulted in a review of contract management procedures to ensure greater clarity and customer focus.

Northern Ireland Housing Executive: Failures in complaint handling and poor record keeping

The Ombudsman was asked to investigate alleged maladministration relating to a complaint made to the NIHE about substandard work as part of the Group Repair Scheme.

The complainant stated that the NIHE had chosen to ignore the complaint and that it failed to follow its own complaints procedures. The complainant also stated that, had her complaint not been 'ignored' by the NIHE, she would not have had to initiate legal proceedings.

The Ombudsman found maladministration and injustice by the NIHE for failing to act in accordance with its own complaints procedure, and for not adequately communicating with the complainant during the handling of her 'correspondence'. In addition the NIHE had failed to monitor the outcome of the referral to the Contractor in co-ordinating a response to address the complainant's concerns; and importantly had failed to keep proper and appropriate records.

The NIHE apologised and also reviewed their contract management procedures for dealing with Group Repair Scheme related complaints.

Northern Ireland Ombudsman, Annual Report of the Assembly Ombudsman for Northern Ireland and the Northern Ireland Commissioner for Complaints, 2012-2013

Principle 7

Create good quality records

This can be achieved by:

(i) Keeping records which are accurate.

Public bodies should:

ensure that facts recorded are accurate and should be an accurate reflection of the transactions they document. A good record will reflect the facts about the given activity. To be reliable, these facts should be correct.

(ii) Keeping records which are comprehensive.

Public bodies should:

ensure that records are supported by information about the circumstances in which they were created and used. Records cannot be fully understood without adequate knowledge of the activity that gave rise to them, the wider function of which that activity forms part, and the administrative context, including the identities and roles of the various participants in the activity.

(iii) Keeping records which are reliable.

Public bodies should:

ensure that it is possible to prove that records created are what they purport to be. It goes without saying that if a record is worth keeping it is worth keeping well, so that there can be no doubt as to its reliability as evidence of the past and for use in the future. Where information is later added to an existing document within a record, the added information must be signed and dated. With electronic records, changes and additions must be identifiable through audit trails.

Case Studies

The following two cases, investigated by the Parliamentary and Health Service Ombudsman, illustrate the importance of keeping information confidential and ensuring comprehensive and reliable records are kept.

The need for 'accurate' records in the information sharing context is highlighted in the Parliamentary Ombudsman's investigation below.

HM Revenue & Customs, Child Support Agency and Department for Work and Pensions: A breach of confidence

Ms M complained that without her knowledge, her address details were entered incorrectly on one government agency's computer system, resulting in her personal details being changed across a network of government computer systems that linked HM Revenue & Customs, the Child Support Agency and the Department for Work and Pensions.

As a consequence of the original mistake her personal 'financial' information was sent to her former partner. Her child support entitlement was also reassessed and reduced without her knowledge. When Ms M queried this error, none of bodies involved had been able to explain satisfactorily what had gone wrong and none had therefore taken steps to resolve her complaint. Ms M found the experience distressing and was compelled to spend time and money ensuring that her records were correct.

The Ombudsman found maladministration and public service failure by HM Revenue & Customs, the Child Support Agency and the Department for Work and Pensions. The Ombudsman's recommendations included; that HM Revenue & Customs apologise on behalf of all the organisations; they pay Ms M £2000; and a check should be carried out on databases of all the relevant organisations to ensure that Ms M's address was correctly recorded. The Ombudsman also recommended that the three departments and the Cabinet Office work together to agree a customer focused protocol for dealing with such complaints.

The Ombudsman's recommendations were agreed in full.

Parliamentary and Health Service Ombudsman, A breach of confidence – A report by the Parliamentary Ombudsman on an investigation of a complaint about HM Revenue & Customs, the Child Support Agency and the Department for Work and Pensions, 2011.

In the following case, the identified failures in records management was set against a background of serious failures in care and the Ombudsman found maladministration in respect of both issues.

Surrey and Borders Partnership Foundation NHS Trust: Mr L's Story – serious failures in care and poor record keeping

Mr L was 72 and suffered from Parkinson's disease. He was taken to A&E after experiencing episodes of hallucinations and paranoia and then transferred to hospital. Mr L was said to be 'in a calm and pleasant mood', but was given 10mg olanzapine, an antipsychotic drug. Mrs L visited her husband later the same day and was 'devastated' by what she saw saying that he had been 'turned into a zombie, a ragdoll'. Over the next few days, despite his family's concerns, Mr L was given more antipsychotic and tranquillising medication, which his family say robbed him of his dignity – he had to be taken to the toilet, could not walk unaided, had to be fed and could not speak coherently.

Mr L was transferred to a general hospital for a routine echocardiogram, but on arrival, he complained of shortness of breath and a cough. On examination, crackles were heard in both lungs and he was dehydrated. A chest X-ray indicated that Mr L had pneumonia. He did not recover and died two weeks later.

Although it had not been unreasonable to prescribe olanzapine the initial dose was incautious and too high for an elderly man with his symptoms. The prescription was changed to a lower dose, to be given as required. But this new instruction was not written up on the drugs chart and the nurses continued to give Mr L olanzapine on a regular basis, even though he did not meet the criteria for its administration.

Shortcomings in care meant that Mr L's deteriorating physical health went unnoticed and there was no evidence that care plans were drawn up to meet his physical needs. Fluid charts showed that he was at severe risk of dehydration yet nursing staff did not respond accordingly. The nursing records fell short of the required standards, led to a failure to recognise the implications of the observations that were made or to take appropriate action to respond.

There was no evidence that regular nursing observations were taken and none were recorded. This meant that while the Ombudsman found no evidence that Mr L showed signs of pneumonia during his time at hospital, staff did not put themselves in a position to be able to state confidently that Mr L was well when he left them.

The care and treatment given fell significantly below the applicable standard and this service failure put Mr L at greater risk, probably contributed to his decline in physical and mental health and loss of dignity, and compromised his ability to survive pneumonia.

This was an injustice to the patient and his family who found it 'heartbreaking' to see his deteriorating condition. The Trust apologised to Mrs L and drew up an action plan aimed at ensuring that lessons were learned and errors not repeated.

Parliamentary and Health Service Ombudsman, Care and Compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people, 2011

The importance of good record keeping in the health sector is also emphasised in the Good Medical Practice guidance issued by the General Medical Council. This can be found on their website, at **www.gmc-uk.org.**

Principle 8

Manage records effectively

This can be achieved by:

(i) Ensuring that all staff are aware of what is expected of them in regards to records.

Public bodies should ensure that staff at all levels are aware of:

- What records to keep
- Where to keep them
- Who should keep them
- When to keep them

(ii) Managing records according to recognised standards, following a records management programme.

Public bodies should:

a. Identify what should be kept, according to statutory duty or business need. Decisions as to what records are to be kept should be documented in a way that can be used by staff in their daily work and can serve as evidence of the organisation's intentions

b. Never destroy a record without having the authority to do so. Good records management aims to ensure that retention decisions are made rationally, and shows why any particular records were destroyed. The existence of a structured retention system allows the organisation to prove that any destruction took place as part of normal business practice

c. Adhere to the Lord Chancellor's Code of Practice on the management of records issued under section 46 of the Freedom of Information Act 2000

The following Information Commissioner's Office case study highlights the action that may be taken when an organisation fails to manage records properly.

Case Study

Department of Justice (NI)

The Compensation Agency Northern Ireland (CANI) moved offices in February 2012 and surplus furniture was to be sold at auction. A locked four drawer filing cabinet was then taken out of local storage without checking its contents and sent to a shared storage facility prior to its disposal. Subsequently, the locked filing cabinet was presented to a local auctioneer for a valuation again without checking its contents. The cabinet was then sold and opened by a member of the public. The official papers contained (among other things) a limited amount of confidential, ministerial advice and highly sensitive personal data, which was returned by the member of the public. As a result of this breach of data protection, the Information Commissioner issued a monetary penalty notice on the Department of Justice for £185,000. The Department of Justice have now revised their records procedures and policies with enhanced training for staff in light of this issue.

(iii) Maintaining records in such a way that they are both retrievable and usable.

Public bodies should:

ensure that records are stored and managed in such a way that they can be discovered when there is a need to consult them. There should be measures in place to ensure that retrieval is efficient and that the records have been appropriately stored.

Case Studies

The following two cases, decided by the Northern Ireland Ombudsman and the Public Services Ombudsman for Wales respectively, illustrate the importance of managing records effectively, to recognised standards and maintaining records in such a way that they are both retrievable and usable.

Early destruction of records to support the decision making and assessment of inspections was found by the Northern Ireland Ombudsman to constitute maladministration because it denied the complainant the opportunity to challenge and question the detail of matters which have given rise to the criticisms highlighted in the inspection report.

Department of Education: information retention and early destruction of records

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

The Ombudsman's investigation found evidence of maladministration on the part of ETI in relation to the premature destruction of records of the follow-up school inspection. The Ombudsman was satisfied that this action meant that the complainant was effectively denied her fundamental right to challenge and question the detail of the matters which gave rise to the criticism. This practice also failed to take

account of the need to respond to any enquiries that the Ombudsman or any other party might make in the event that the complainant challenged or queried ETI's actions beyond the scope of its own internal complaints process. The Ombudsman also identified maladministration in the ETI's complaints handling processes, although the Ombudsman was satisfied that the complainant did not sustain an injustice in consequence. The practice of early destruction of data had already ceased at the time of the investigation.

The Ombudsman recommended that the follow-up inspection report should be withdrawn as it could not be relied upon. The Permanent Secretary of the Department of Education accepted these findings and met the recommendation. ETI, by way of follow up, has taken practical measures to improve its complaints handling processes.

Northern Ireland Ombudsman, Annual Report of the Assembly Ombudsman for Northern Ireland and the Northern Ireland Commissioner for Complaints, 2012-2013

The need for robust procedures for filing, tracking and retrieving records is an important part of effective records management and this is highlighted by the following case study.

The case relates to the patient's experience, care and treatment in a Welsh Hospital. While the Public Services Ombudsman for Wales did not find failures in care and treatment of the elderly patient, he was critical about the failures in records management. This he found to constitute maladministration. The hospital reviewed its procedures for managing patients' medical records as a result of the Ombudsman's intervention.

Abertawe Bro Morgannwg University Health Board: medical notes mislaid

Mrs D complained about the care and treatment provided to her elderly father, Mr A, who had dementia. In particular, she complained about the level of medication prescribed to Mr A which she said led to his being overly sedated. She felt that this contributed to the fact that he

fell and broke his hip shortly after his admission. She queried the accounts given of his fall. Mr A sadly died several months later.

Having obtained clinical advice, the Ombudsman found that the level of medication prescribed to Mr A was in line with accepted clinical guidelines and Mr A's presenting condition. The complaint about the clinical care was not upheld.

The Ombudsman partly upheld the complaint about the reporting of Mr A's fall. The incident report form detailing Mr A's fall was inaccurate and incomplete. During the course of the investigation, it transpired that the Health Board was unable to locate Mr A's original medical notes for over seven months until after a draft of this report was issued. This was unacceptable and called into question the robustness of the Health Board's procedures for tracking and filing its records.

The Ombudsman recommended that the Health Board should apologise to Mrs D and review its arrangements both for reporting and investigating incidents. It was also recommended that procedures for tracking and filing its clinical records should be reviewed in order to ensure that the system was robust. This was particularly in respect of mental health records.

Public Services Ombudsman for Wales, The Ombudsman's Case Book, January 2013

Useful Websites:

The following websites provide further information and guidance on the principles of good administration and good records management practice.

Northern Ireland Ombudsman
www.ni-ombudsman.org.uk

Ombudsman's Association
www.ombudsmanassociation.org

Parliamentary and Health Service Ombudsman, England
www.ombudsman.org.uk

Public Services Ombudsman for Wales
www.ombudsman-wales.org.uk

Scottish Public Services Ombudsman
www.spso.org.uk

The Office of the Ombudsman and Information Commissioner, Ireland
www.ombudsman.gov.ie

Irish Data Protection Commissioner
www.dataprotection.ie

Scottish Information Commissioner
www.itspublicknowledge.info

Public Record Office of Northern Ireland
www.proni.gov.uk

National Archives
www.nationalarchives.gov.uk

National Archives of Ireland
www.nationalarchives.ie

National Records of Scotland
www.nrscotland.gov.uk

Information Commissioner
www.ico.org.uk

General Medical Council
www.gmc-uk.org

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Published 2014 by the Northern Ireland Ombudsman's Office.

Good Administration and Good Records Management

The Eight Principles

ISBN: 978-0-9542883-9-6