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The Northern Ireland Public Services Ombudsman's Report into Personal Independence Payment and Collective Administrative Justice (Pt 1)

(2023) 30 Journal of Social Security Law (forthcoming)

ROBERT THOMAS[*]

Abstract

Benefit decision-making is often criticised for its variable quality. Individual redress through tribunals is necessary, but insufficient. More comprehensive forms of collective justice are required to uncover the underlying structural causes of poor-quality decision-making. One such mechanism is the own-initiative powers of ombudsmen to investigate systemic maladministration. This article evaluates the first own-initiative investigation undertaken by a UK ombudsman—that of the Northern Ireland Public Services Ombudsman into Personal Independence Payments. It does so by examining the Ombudsman's investigation, the contexts in which it arose, its significance and the response of government to it. The article argues that the Ombudsman's investigation exemplifies the wider emerging endeavour of collective justice. It complements individual redress mechanisms and provides a depth and breadth of scrutiny that they cannot. The Ombudsman's PIP investigation has both made government accountable and led to important changes to the PIP system. At the same time, the scale and ambition of achieving collective justice through an own-initiative investigation are matched by the challenges in securing systemic improvements. The article is structured in two parts. Part 1 examines the conceptual and practical differences between individual and collective justice, the Ombudsman's own-initiative powers, the PIP system, the Ombudsman's detailed findings and how the systemic maladministration became deeply embedded within the institutional culture of the PIP system. Part 2 considers the Ombudsman's recommendations, the response of government, its progress in implementing those recommendations and in improving the PIP system, the challenges involved and the wider significance of the investigation.

Introduction

Benefit decision-making is often criticised for its variable quality. The long-established means of redress is through individual justice mechanisms, principally administrative reviews, complaints and tribunals. These mechanisms can enable individuals to secure justice. Government may then use the learning produced to improve for the future. However, there are significant practical shortcomings with this model of individual justice. Many people do not seek redress. The ability and willingness of government to engage in organisational learning is limited, especially when the feedback is contained in a multitude of individual decisions. An alternative and emergent model is that of collective justice. This involves wider and deeper scrutiny of the operation of an entire administrative system by an independent body, which makes findings and recommendations to address the systemic failures identified. This article argues that collective justice has an increasingly important role to play and its role should be augmented. It is not a panacea. There are certainly complications and challenges. Nonetheless, thinking about and pursuing justice through collective and systemically focused scrutiny can bring important benefits far beyond the reach of individual justice mechanisms. Accordingly, collective justice holds significant promise in terms of both diagnosing structural problems within

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government that adversely affect people and potentially improving how public services are organised and delivered.

To support this argument and to explore these matters, the article examines and evaluates the own-initiative investigation by the Northern Ireland Public Services Ombudsman (the Ombudsman) into the delivery of Personal Independence Payments (PIP) in Northern Ireland (NI) by the Department for Communities (the Department).[1] The Ombudsman found that there was systemic maladministration in the PIP system. The core structural problem was that the Department—and its external assessment provider, Capita—had failed properly to collect and use further evidence from claimants' health professionals in order to make good quality decisions concerning their entitlements to PIP. Such evidence is critically important in getting decisions right and ensuring claimants receive their entitlements. In 2023, the Ombudsman published a follow-up report on the Department's progress with delivering the recommendations made.[2]

The Ombudsman's investigation is a major landmark. It is the first own-initiative investigation undertaken by a UK ombudsman. The report provides an extremely detailed empirically based analysis of how PIP is administered on which extensive findings and recommendations are based. It amounts to a "systemic administrative justice audit". Its findings illustrate and confirm wider concerns about the quality of benefit decisions and the wider systems, cultures and mindsets through which they are made. The report also reveals the territorial, organisational and institutional-cultural complexities of PIP delivery in NI. It invites comparison with other parts of the UK and other ombudsmen. This article provides a critical analysis of the importance of the Ombudsman's report and its contribution to enhancing the delivery of PIP and administrative justice.

The article is structured as follows. Part 1 situates the own-initiative powers of ombudsmen within the wider context of access to justice and, in particular, the conceptual and practical differences between individual and collective access to justice. It then examines the Ombudsman's own-initiative powers and the PIP system before considering the detail of the report's findings. The Ombudsman identified multiple administrative, procedural, governance, communication and other failures. The article then considers the Ombudsman's wider findings relating to the institutional cultures which simultaneously generated the systemic maladministration and rendered the Department unable to identify it and indeed to deny its existence. The discussion is framed within the wider problem of how to legitimate administrative decision-making. Part 2 examines the Ombudsman's recommendations, the response of the Department and its progress in implementing them and thereby improving the PIP system. It also evaluates the wider implications and significance of the report and the own-initiative powers of ombudsmen. Overall, it is argued that the PIP investigation has been a successful use of own-initiative powers. The Ombudsman has made government accountable by undertaking unprecedented scrutiny of the administration of PIP. It has also secured various improvements to the PIP process and decision-making—not just in NI, but also in rest of the UK. Nonetheless, there are distinct limits to what has been achieved as confirmed by the Department's response to the Ombudsman's recommendations. The full practical impact of the report and its recommendations remains to be seen.

Individual and collective justice

Access to justice is typically understood in terms of *individual* redress. For instance, a person appeals a benefit decision to a tribunal or makes a complaint. Individual redress is important for the individuals

[1] Northern Ireland Public Services Ombudsman, *PIP and the Value of Further Evidence* (2021).
[2] Northern Ireland Public Services Ombudsman, *PIP and the Value of Further Evidence: Follow Up Report* (2023).

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concerned as illustrated by the high volume of successful appeals.[3] This individuated model dominates almost all thinking about access to justice despite the fact that it denotes a relatively confined and restrictive understanding. In response, the notion of *collective* access to justice has increasingly been recognised.[4] It typically arises when a group or a cohort of similarly situated people share common characteristics and experience an aggregate and collective justice problem. This problem reflects, but also transcends, those individuals' specific circumstances. For instance, the group of people rely upon a government body or public service, such as benefits, but the delivery of that service is or may be systemically flawed in a structural, cultural and/or behavioural way. In such situations, the need for collective justice is naturally associated with—and indeed by generated by—those underlying systemic failures which adversely affect the wider group of people. The nature of that collective injustice problem can then be reinforced by common characteristics of the relevant population if, for instance, they are a largely vulnerable group of people who lack agency and the resources and ability to take action for themselves.

In this situation, individual justice remains necessary, but it is no longer sufficient. Indeed, individual redress can, in some instances, reinforce and potentially exacerbate the underlying and collective justice problem. Only a small fraction of people use tribunals. Many lack the confidence to do so and find the process both stressful and lengthy.[5] There is also a significant inequality between "one-shotter" claimants and the "repeat-player" government department.[6] Even when people access tribunals, their problems are resolved on an individualised case-by-case basis. There is rarely sufficient recognition that there is a wider collective justice problem that needs to be addressed. Even if there is, the role of tribunals is limited because of their judicial character. They cannot consider the structural causes of injustice. Accordingly, a model of collective justice is required to identify and correct the underlying causes that generate the multiple instances of individual injustice.

Other aspects of collective justice can be highlighted. Given the wider nature of the endeavour, collective justice will affect a whole cohort of people. This will naturally overlap with social movements and political campaigns by stakeholders. Another feature is that collective justice is focused upon identifying and fixing underlying causes, not just their surface-level symptoms. For this reason, the methods, solutions and remedies of collective justice necessarily go far beyond individual redress. Diagnosing and understanding the underlying systemic problem can involve the extensive collection and analysis of data which provide the basis for findings and reforms. The next stage is then to make recommendations in an attempt to resolve, or at least ameliorate, the weaknesses identified. The final stage is to then implement those recommendations. This will typically require structural and behavioural improvements through further governmental action and systemic reforms. There will also be the need for follow-up scrutiny to test whether the recommendations have become embedded and to guard against any relapse over time.

Another feature of collective injustice is that its structural causes are typically far more challenging and difficult to resolve precisely because of their multi-factorial complexity. In contexts, such as benefits, the underlying causes may well be found in deep-seated systemic and cultural weaknesses within administrative systems. They may also involve and implicate other actors, such as private providers. Resolving collective injustices is a far more complex and ambitious endeavour than providing individual redress. It is also more high risk because it is potentially politically controversial and may

[3] Over recent years, the proportion of allowed PIP appeals has averaged 60–70%. See *Tribunal Statistics Quarterly* (London: Ministry of Justice, 2023).
[4] See, e.g. C. Hodges and S. Voet, *Delivering Collective Redress: New Technologies* (Oxford: Hart, 2018); M. Molavi, *Collective Access to Justice: Assessing the Potential of Class Actions in England and Wales* (Bristol: Bristol University Press, 2021).
[5] J. Durrant, *Access Denied: Barriers to Justice in the Disability Benefits System* (London: Z2K, 2018).
[6] M. Galanter, "Why the 'Haves' Come Out Ahead: Speculations on the Limits of Legal Change" (1974) 9 *Law and Society Review* 95.

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have significant financial and organisational consequences. Nonetheless, such efforts are manifestly required to meet a real and collective social need. They also reflect wider concerns about how the relevant group of people have been treated. The injustice problems such people experience will likely resonant more widely and thereby reinforce the need for them to be resolved.

Ombudsmen and own-initiative powers

The distinction between individual and collective justice is not binary, but more of a spectrum. It can be seen reflected in the role of tribunals and the own-initiative powers of ombudsmen. Conventionally, ombudsmen handle individual complaints one at a time.[7] However, some ombudsmen now have own-initiative powers to investigate systemic maladministration.[8] The NI Ombudsman was the first to acquire such powers.[9] The rationale was that the Ombudsman could proactively investigate matters of concern, especially those affecting a wide number of people unlikely or unable to complain.[10]

To undertake an own-initiative investigation, the Ombudsman must have a reasonable suspicion of systemic maladministration.[11] To identify a matter for a potential investigation, the Ombudsman draws upon various sources: public concern about the issue; a pattern of complaints or a lack of them; and media, government and other reports.[12] When deciding whether to launch an own-initiative investigation, the Ombudsman considers whether the issue raises public interest concerns and/or affects a number of people or group, whether an investigation could potentially improve public services and whether it would be the best and most proportionate use of the Ombudsman's resources. The Ombudsman must prepare an investigation proposal, consult with other oversight bodies, gather information by making strategic inquiries and agree the terms of reference with the relevant government body.[13] From the Ombudsman's perspective, all of this provides an iterative process enabling it to consider carefully the subject matter, understand the risk areas for people affected and to ensure a fair and proportionate use of own-initiative powers to investigate matters that raise significant concern.[14]

As with all statutory powers, the real test of own-initiative powers is not their formal presence on the statute book, but how they are exercised in practice and the quality and impacts of the investigation for both society and government. These are important aspects of the ombudsman enterprise, namely trying to improve government and the services people rely upon. To this end, the Ombudsman scrutinises governmental behaviours and makes recommendations. It also tries to get government to embed the

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[7] T. Buck, R. Kirkham and B. Thompson, *The Ombudsman Enterprise and Administrative Justice* (London: Ashgate, 2011). Ombudsmen can investigate benefit complaints after following various prior stages have been completed, although in practice relatively few benefit complaints actually reach ombudsmen: R. Thomas, "Benefit Complaints: A Critical Analysis" (2022) 44 *Journal of Social Welfare and Family Law* 258.

[8] C. Gill, "The Ombud and Own-initiative Investigation Powers" in R. Kirkham and C. Gill (eds), *A Manifesto for Ombudsman Reform* (London: Palgrave, 2020); R. Thomas, "Analysing Systemic Administrative Failures: Explanatory Factors and Prospects for Future Research" (2021) 43 *Journal of Social Welfare and Family Law* 339.

[9] Public Services Ombudsman Act (Northern Ireland) 2016 s.8. The only other UK ombudsman with such powers is the Public Services Ombudsman for Wales (PSOW). See PSOW, *Homelessness Reviewed: An Open Door to Positive Change* (2021). The Parliamentary and Health Service Ombudsman, the Local Government and Social Care Ombudsman and the Scottish Public Services Ombudsman do not have own-initiative powers.

[10] Committee for the Office of the First Minister and Deputy First Minister, *Report on the Committee's Proposals for a Northern Ireland Public Services Ombudsman Bill Volume One* (Seventh Report, 2013), [187]–[195] and [219]; Northern Ireland Assembly, *Research and Information Service Briefing Paper: Own-motion Investigations by Ombudsmen* (Paper 80/15, 2014).

[11] Public Services Ombudsman Act (Northern Ireland) 2016 s.8(4).

[12] Northern Ireland Public Services Ombudsman, *Information Leaflet: Own Initiative Investigations* at *https://www.nipso.org.uk/investigations/own-initiative-investigations*.

[13] Public Services Ombudsman Act (Northern Ireland) 2016 ss.29 and 51.

[14] Northern Ireland Public Services Ombudsman, *PIP and the Value of Further Evidence* (2021), p.36.

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principles of good administration not just within its procedures, but also its institutional approach and mindset. Own-initiative powers enable the Ombudsman to focus its resources on matters of significant concern that affect the wider public, not just individual complainants, and can ensure systemic failings are identified and potentially addressed. Such powers are a critically important of means of "tackling service failures about which vulnerable individuals may be unable, or feel afraid, to complain".[15] This is precisely what the Ombudsman sought to undertake in relation to PIP.

The PIP system

PIP is the non-means tested disability benefit for people of working age to help with the additional costs arising from long-term health conditions or disabilities.[16] It was introduced in NI in 2016 and is administered by the Department for Communities.[17] As happens in the rest of the UK (except Scotland), the assessments used to assess the impact of claimants' condition(s) or impairment on their functional ability have been outsourced.[18] These assessments are a critically important part of the PIP process. They provide advice to the Department's case managers who then take formal decisions on claimants' entitlements. Before examining the Ombudsman's report in detail, it must be situated within its various wider contexts: the organisational character of the system; its specific territorial context in NI; and the problem of further evidence.

PIP was an obvious choice for an own-initiative investigation. It is a large administrative system that many people interact with. Any systemic problem inevitably affects a large number of people. PIP decisions involve sensitive and complex exercises of judgement. Decision-makers consider the impact of a person's health conditions on their functional ability as prescribed in the PIP descriptors. Claimants have a wide range of conditions.[19] Some are amongst the most vulnerable people in society. However, because there are so many claims, there has to be some sort of administrative system to process and manage them. This system must both produce good decisions and be efficient. The resultant trade-offs here condition both the operation of the whole system and also its scrutiny.

In general terms, government agencies that administer benefits reflect a general organisational model, the programmed machine. This is a large process-based siloed organisation that works on the basis of hierarchy and rules.[20] Its purpose is to undertake a large number of standardised repetitive tasks efficiently. Accordingly, there is an obsession with hierarchy, rules, targets and control, particularly the amount of time and money involved in each interaction. Programmed machines are the only feasible way of managing a large caseload, but they are also often dysfunctional. They prioritise efficiency and volume over quality. Staff often become alienated. There is also disconnect at the top. Senior officials may not understand what is happening within front-line operations. They rely upon incomplete quantitative management information. This may identify problems, but softer, more qualitative information is usually required to diagnose and resolve them. Other complications arise from the outsourcing of assessments. The dual-institutional structure of government department and contractor

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[15] Northern Ireland Public Services Ombudsman, *PIP and the Value of Further Evidence* (2021), p.35.

[16] Welfare Reform Act 2012 Pt IV. PIP replaced Disability Living Allowance (DLA).

[17] Welfare Reform (Northern Ireland) Order 2015 (NISR 2015/2006); Personal Independence Payment Regulations (Northern Ireland) 2016 (NISR 2016/217).

[18] In Scotland, PIP—known as Adult Disability Payment—is gradually being rolled out by Social Security Scotland. The outsourcing of assessments to private sector contractors is prohibited: Social Security (Scotland) Act 2018 s.12. See M. Simpson, G. McKeever and A.M. Gray, "From Principles to Practice: Social Security in the Scottish Laboratory of Democracy" (2018) 26 J.S.S.L. 13.

[19] These conditions include, for instance, fibromyalgia and chronic pain, mental health conditions, paranoid psychosis, PTSD, depression and anxiety, Parkinson's disease, schizophrenia, severe chronic obstructive pulmonary disease, dyspraxia (verbal, oral, developmental), dyslexia, muscular dystrophy, ADHD, sensory problems and anxiety, diabetes neuropathy, mobility issues, arthritis and asthma amongst others.

[20] H. Mintzberg, *Understanding Organizations—Finally!* (Oakland, CA: Berrett-Koehler, 2023), Ch.8.

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can fragment operations, heighten disconnection and make the department reliant upon the contractor. The use of contract as the means by which government manages the contractor introduces inflexibility and additional costs when seeking to improve the contractor's performance. These features are present in the PIP system.[21]

We need to place this system within the specific territorial context of NI. Social security is devolved to NI, but, in practice, the principle of parity means that NI adopts the same policies and laws as Britain.[22] In some respects, this can be advantageous. The later implementation of PIP in NI enabled it to avoid the extensive delays and problems that characterised the initial roll-out of PIP in Britain.[23] On the other hand, there is a significant dependency by the Department on the frameworks, IT systems and administrative structures of the Department for Work and Pensions (DWP).[24] This significantly constrains the degree of flexibility in NI when it comes to changing and improving systems. There are common concerns about the quality of assessments and decisions, high appeal success rates and a consequent lack of trust in the process.[25] It is also notable that PIP has a particular social significance in NI where it is claimed by a higher proportion of the population (11%) than in Britain (5%).[26] It is therefore a large system that a significant proportion of the people in NI interact with and rely upon.

Within these contexts, a crucially important procedural-substantive matter arises: the collection of further evidence about claimants' conditions in order to make robust decisions. Good decision-making depends upon decision-makers having as much evidence as possible. In the PIP context, the evidence includes information from claimants and their assessments. It also includes further evidence from their health professionals.[27] Such professionals will know about a claimant's conditions and will therefore be able to give more detailed, thorough and expert evidence compared with, for instance, an assessment undertaken by a generalist assessor. Further evidence is a seemingly procedural matter, but it significantly impacts upon the substantive quality of decisions and therefore claimants' entitlements. Its importance is reinforced by the largely vulnerable nature of claimants many of whom are unable or reluctant to challenge decisions once they have been taken.

Who is responsible for collecting further evidence? And what actually happens in practice? In formal-legal terms, initial benefit decision-making and appeals are not a form of adversarial litigation in which claimants bear the burden of proof. They are an investigative and co-operative fact-gathering exercise to which both claimants and the Department must contribute. The Department must undertake its own

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[21] National Audit Office, *Contracted-out Health and Disability Assessments* (HC 609 2015–16); House of Commons Work and Pensions Committee, *PIP and ESA Assessments* (HC 829 2017–19) and *Health Assessments for Benefits* (HC 128 2022–23).

[22] D. Birrell and D. Heenan, "Devolution and Social Security: The Anomaly of Northern Ireland" (2010) 18 *Journal of Poverty and Social Justice* 281; M. Simpson, *Social Citizenship in an Age of Welfare Regionalism: The State of the Social Union* (Oxford: Hart, 2022), pp.145–152.

[23] National Audit Office, *Personal Independence Payment: Early Progress* (HC 1070 2013–14); House of Commons Public Accounts Committee, *Personal Independence Payment* (HC 280 2014–15); *R. (on the application of C) v Secretary of State for Work and Pensions* [2015] EWHC 1607 (Admin); [2015] A.C.D. 118.

[24] e.g. the NI Department undertakes the same corrective "LEAP" administrative exercises as the DWP. See "Stormont to Review PIP Benefit Claims after Court Ruling" *BBC News* 7 February 2018; R. Thomas, "Legal Entitlements and Administrative Practices: LEAP Exercises and Benefits Administration" (2022) 29 J.S.S.L. 49.

[25] House of Commons Work and Pensions Committee, *PIP and ESA Assessments* (HC 829 2017–19); Northern Ireland Audit Office, *The Management and Delivery of the Personal Independence Payment Contract in Northern Ireland* (2021).

[26] Northern Ireland Audit Office, *The Management and Delivery of the Personal Independence Payment Contract in Northern Ireland* (2021), p.12; Department for Communities, *Personal Independence Payment (PIP) Statistics* (February 2023).

[27] e.g. from the claimant's general practitioner, community psychiatric nurse, care co-ordinator or other key worker. Further evidence also includes claimants' prescription lists and care or treatment plans.

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inquiries to supplement the information given by claimants.[28] This co-operative shared duty reflects a wider normative relationship between claimants and the welfare state based upon a set of reciprocal set of rights and responsibilities. Claimants are entitled to good decisions which the state should make in the interests of individual claimants and the public as a whole.

However, this formal legal position is just not reflected in administrative-behavioural reality. Concerns have been repeatedly raised that neither the Department nor its contractor collect further evidence from claimants' health professionals in order to improve the evidence base of decisions.[29] The President of NI Appeal Tribunals has consistently highlighted that tribunals have allowed many appeals on the basis of further evidence that was not considered earlier in the process, but could have been.[30] A related criticism has concerned the variable quality of the outsourced assessments. The assessors lack anything like the professional expertise of qualified medical practitioners.[31] Accordingly, the President has emphasised the need to collect further evidence from health professionals earlier in the process. However, the Department failed to act, an outcome that was "deeply disappointing and … most unfair to claimants" some of whom then experience the "trauma" of providing "unnecessary oral evidence" before tribunals.[32] Stakeholders and advisors have raised similar concerns.[33]

The PIP investigation

In 2019, the Ombudsman launched its own-initiative investigation with the issue of further evidence as its focus as a matter of significant and reoccurring concern.[34] The Ombudsman had received individual complaints suggesting confusion over who was responsible for gathering further evidence. The high number of appeals allowed by tribunals had highlighted potential shortcomings in the collection of evidence by the Department and Capita and the risk that vulnerable claimants who do not appeal could lose out on their entitlements. Concerns has also been raised through the media and by stakeholders and NI Assembly members.[35]

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[28] *Kerr v Department for Social Development* [2004] UKHL 23; [2004] 1 W.L.R. 1372 at [15] (Lord Hope) and [62] (Baroness Hale). See also *R. v Medical Appeal Tribunal (North Midland Region) Ex p. Hubble* [1958] 2 Q.B. 228 at 240 (Diplock J); [1958] 3 W.L.R. 24. The *Kerr* dicta was incorporated within internal guidance: Department for Communities, *Department Advice for Decision Making Guide*, Ch.A1: Principles of decision making and Evidence (2019) A1405 (initially the burden lies with claimants to prove their claim, but decision-makers "should do as much as possible to ensure that the claimant has every opportunity to provide all relevant evidence and where the information is available to them rather than the claimant, then they must take the necessary steps to enable it to be traced").

[29] Northern Ireland Audit Office, *Decision-Making and Disability Living Allowance* (HC 43 2005–06), pp.11–12. The same concerns have been raised in relation to the DWP: National Audit Office, *Getting it Right, Putting it Right: Improving Decision-Making and Appeals in Social Security Benefits* (HC 1142 2002–2003); *Reports by the President of Appeal Tribunals on the standards of decision-making by the DWP 2001–2008; Annual reports of the DWP Decision Making Standards Committee 2001–2010*.

[30] *Annual reports of the President of NI Appeal Tribunals on the standards of decision making by the Department, 2016–2022*.

[31] President of NI Appeal Tribunals, *Annual Report 2018–19* (2022), p.3.

[32] President of NI Appeal Tribunals, *Annual Report 2018–19* (2022), pp.2–3. The Department also failed to act when the same point was raised by its own independent review of PIP: W. Rader, *Personal Independence Payment: An Independent Review of the Assessment Process* (2018).

[33] See, e.g. Advice NI, *Response to Second Independent Review of the Personal Independence Payment (PIP) Assessment Process in Northern Ireland* (2020).

[34] "PIP investigation proposed by NI Ombudsman Marie Anderson" *BBC News* 21 January 2019; "PIP: Ombudsman to start benefits investigation" *BBC News* 24 June 2019.

[35] "Third of NI DLA claimants' benefits stopped" *BBC News* 8 November 2017; "PIP disability benefit: Concerns raised over NI assessments" *BBC News* 11 November 2017; "PIP: New benefits system 'demeaning and degrading'" *BBC News* 1 May 2018; "PIP assessments: Call to change 'inhumane' benefit system" *BBC News* 30

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Previous scrutiny of PIP by external reviewers and the Northern Ireland Audit Office raised the possible risk of a duplication of scrutiny.[36] However, the Ombudsman emphasised its distinctive role within the wider scrutiny landscape. It would test the delivery of PIP against the principles of good administration thereby providing "a unique administrative justice lens to examine and potentially improve this area of public service delivery".[37] These principles—getting it right; being customer focused; being open and accountable; acting fairly and proportionately; putting things right; and seeking continuous improvement—embody a set of normative values about how public bodies (and their contractors) should behave toward people.[38] They also define the Ombudsman's role, its assessment of service delivery and its recommendations. The Ombudsman was "very alert to the significant impact that failings in public administration can have on individuals' lives and the extent to which such failings can seriously damage confidence in public services".[39]

A distinctive feature of own-initiative investigations is that they involve the Ombudsman scrutinising an entire system and its practical operation. This required the extensive collection data to assess whether there was systemic maladministration.[40] One issue here concerns the applicable standard. The Ombudsman's approach is that systemic maladministration does not necessarily mean that the same failing must occur in a majority of cases. It is sufficient if the same issue/failing has repeatedly occurred and is likely to persist if left unremedied; or alternatively, if a combination or series of failings have occurred and are likely to recur.[41] This involves significant judgement and is an appropriate standard to identify systemic maladministration. After all, if flaws in a decision process caused problems or errors in, for instance, a third of decisions, then this would affect a significant proportion of all people and therefore be systemic.

A final point concerns the relationship between the Ombudsman and the Department. The Department may have been somewhat defensive about the Ombudsman's intervention in a sensitive area. Nonetheless, given the recent conferral of own-initiative powers and concerns with PIP, it was not in a position to resist. Emphasising the high-quality service it delivered, the Department put down an initial marker by welcoming any suggested improvements that were "*scaleable* and *practical* within the national PIP framework".[42] The Department's recognition that it administered PIP in the same way as in the rest of the UK was hardly a good initial defensive position, but more of an inadvertent precursor of the Ombudsman's subsequent findings. What is apparent though is that the Department gave the Ombudsman full access and co-operated with the investigation.

The PIP report

This brings us to the PIP report itself, a substantial document of over 300 pages of meticulous detail. The report is complex not just because of its minutiae, but also because it operates on two levels: the formal surface level of administrative procedures and decisions; and the underlying level of system

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April 2018; "PIP appeal left disabled man 'stressed and humiliated'" *BBC News* 18 January 2019; Advice NI, "Concerns about the PIP Assessment Process" (2019).

[36] W. Rader, *Personal Independence Payment: An Independent Review of the Assessment Process* (2018); M. Cavanagh, *Personal Independence Payment: A Second Independent Review of the Assessment Process* (2020); Northern Ireland Audit Office, *The Management and Delivery of the Personal Independence Payment Contract in Northern Ireland* (2021).

[37] Northern Ireland Public Services Ombudsman, *PIP and the Value of Further Evidence* (2021), p.39.

[38] Parliamentary and Health Service Ombudsman, *Principles of Good Administration* (2009).

[39] Northern Ireland Public Services Ombudsman, *PIP and the Value of Further Evidence* (2021), p.34.

[40] The methodology adopted by the investigating team included: reviewing 100 case files; extensive enquires to both the Department and Capita; site visits; and engaging with external stakeholders.

[41] Northern Ireland Public Services Ombudsman, *PIP and the Value of Further Evidence* (2021), p.35.

[42] Department for Communities, "Department responds to Northern Ireland Public Services Ombudsman investigation" 24 June 2019 (emphasis added).

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cultures and mindsets. We can first outline the PIP process and then consider the Ombudsman's detailed findings that multiple aspects of the process contravened good administration.

The PIP process comprises the claimant's application to the Department; an initial review by a Capita assessor to review the evidence and decide on the assessment format; and then the assessment itself. This is undertaken by an assessor who produces an assessment report with advice for the Department's case managers.[43] They then consider the assessment and, if necessary, collect further evidence and then take a "first-tier" decision accompanied by reasons.[44] There are then two successive internal review processes—mandatory reconsideration and a revision stage when an appeal is lodged—and then a tribunal appeal. There are also complaints. The Ombudsman was fundamentally concerned with the behavioural realities of how this system worked in practice and whether it advanced or weakened good administration.

What then did the Ombudsman find? At the application stage, a claimant typically phones the Department's PIP centre and an advisor assesses the claimant's requirements for additional support and record their details. The Ombudsman found communication failures at this stage. Many claimants were misled into thinking that the Department and/or Capita would contact their health professionals to obtain further evidence about their conditions, but this rarely happened in practice. The lack of clear and effective communication with claimants was compounded by a lack of advice to claimants about how to provide their own further evidence. Consequently, claimants could not make an informed decision about providing such evidence. Claimants who applied through the paper-based format were informed that they could access their information concerning their Disability Living Allowance claim to support their PIP claim whereas those applying over the phone (the majority) were not afforded the same opportunity. While claimants—often vulnerable people with disabilities—might require additional support, many did not have their needs appropriately assessed or receive such support.

Following the claimant's application, at the initial review stage, an assessor reviews the available information and decides whether to obtain further evidence and the assessment type (in person or paper). The Ombudsman found that, in the majority of cases, the initial review was the only stage of the decision process where decision-makers (assessors and case managers) considered whether to collect further evidence from claimants' health professionals. However, such evidence was rarely requested—principally because of acute time pressures. Initial reviews were undertaken within nine minutes on average during which assessors had to consider the claimant's application and write it up. These "inappropriate expectations" meant that assessors could not appropriately complete initial reviews thereby "resulting in failures to identify additional health care professionals, low numbers of requests for further evidence and incomplete decision-making records and advice requests".[45] Another reason was that decision-makers assumed that further evidence would not be provided within the timescales required. Assessors were also rewarded with bonuses for the number of initial reviews undertaken. This incentivised them to process as many reviews as quickly as possible. The result was low numbers of requests for further evidence and incomplete decision-making records and advice requests. The failure to request further evidence undermined the principle of getting it right. Guidance on requesting further evidence was not followed. Moreover, the details of claimants' health professionals were not recorded. Accordingly, the Ombudsman was concerned that the Department could not confirm whether assessors had properly considered whether to request further evidence. Nor were claimants informed whether

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[43] Capita assessors are typically former NHS occupational therapists, nurses and physiotherapists. Case managers are junior civil servants.

[44] The "first-tier" decision is the initial entitlement decision and should not be confused with decisions of the First-tier Tribunal. In any event, social security appeals in NI are heard by the Northern Ireland Appeals Service, not the First-tier Tribunal (Social Entitlement Chamber). See generally G. McKeever, "Reforming Social Security Appeal Tribunals in Northern Ireland: Parity Whether we Leggatt or Not?" (2010) 17 J.S.S.L. 71.

[45] Northern Ireland Public Services Ombudsman, *PIP and the Value of Further Evidence* (2021), p.94.

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their health professionals had been contacted. This left them in the dark about as to whether to gather such evidence themselves.

Pausing here, it can be noted how the initial stages of a decision process may often exert significant impact upon its subsequent stages by creating an anchoring effect. Subsequent decisions may rely too heavily on such earlier stages which become a reference point or "anchor". Assessors at the assessment stage and then case managers can request further evidence, although are themselves under time pressures and will therefore likely assume that if further evidence was not requested at the initial review stage, then it is unnecessary to do so.

Next, the assessment itself. The Ombudsman found that assessors repeatedly failed to seek further evidence at this stage. They focused almost exclusively on collecting evidence from claimants in person rather than supplementing this with further evidence from health professionals. Consequently, both assessments and the advice to case managers were often based upon incomplete evidence. Further evidence provided by claimants themselves was neither accepted nor considered. Assessment reports were often inadequate in terms of how assessors had evaluated the further evidence. The justifications given for the weighing of evidence was generally poor. Assessors typically relied upon their own observations at assessments over claimants' accounts or third-party evidence. The overall assumption was that a face-to-face assessment negated the need to request further evidence. This was reinforced by inadequate auditing of assessment reports specifically on whether to request further evidence, which gave false reassurance about their quality.

Assessments are submitted to case managers, the statutory decision-makers responsible for independently examining all the evidence provided and, if necessary, gathering further evidence. However, in practice, case managers overwhelmingly deferred to Capita assessors on both whether to request further evidence and claimants' substantive entitlements to PIP. Case managers did not query the significant differences between the advice provided by assessors and the conditions reported by claimants. Most of the time, decisions were in substance made by assessors and largely signed off by case managers. The latter rarely requested potentially helpful further evidence despite having the responsibility to take the right decisions based upon sufficient evidence. While it was for case managers to ensure that the claimant's individual circumstances had been considered and that their voice was heard, in practice, they did not communicate directly with claimants. There was a repeated failure by case managers to obtain consider further evidence. While PIP decision-making could involve differences of professional judgement, decisions needed to have a firm evidential basis and this was largely absent.

These problems were reinforced by poor reason-giving. The automated nature of the IT system used to generate decision letters and the limited number of characters available frequently resulted in incomprehensible and poorly reasoned decisions. The opinions of assessors were often inappropriately presented as facts. There was also a lack of reference to further evidence and weighing up of that evidence. Decision notices did not explain what evidence had been relied upon or why assessors' findings had been preferred over conflicting further evidence. "Decision letters repeatedly failed to account for how further evidence was considered in the decision making and presented significant challenges to claimants' understanding of the evidential basis for the decisions."[46] Decisions were made, but the "reasons" were inadequate.

The Ombudsman also found significant contradictions between what the Department said it would do and what it actually did. Claimants were to be given every opportunity to provide relevant evidence, but in practice, they were advised only to provide the evidence they already had. This dissuaded them from providing additional further evidence. Claimants were asked to provide the details of their health professionals from whom relevant evidence could be sought, but assessors rarely made such requests.

[46] Northern Ireland Public Services Ombudsman, *PIP and the Value of Further Evidence* (2021), p.148.

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One task of case managers is to consider whether to obtain further evidence, an important matter particularly in those cases where there was a conflict between the claimant's needs and the assessor's recommendation. Such evidence would be valuable to address such matters, especially in light of the potential serious impact of incorrect decisions on claimants. However, this rarely happened. The need to process claims quickly overrode the need to get decisions right.

Similar problems pervaded the mandatory reconsideration stage.[47] Explanation calls—through which the Department provided claimants with further explanations for its decisions—were not recorded thereby preventing claimants from understanding whether their award had been properly considered. Delays added to claimants' frustration. The Department failed to give claimants clear advice about the mandatory reconsideration process. Assessment reports were not routinely disclosed to claimants alongside initial decisions but only when claimants requested them. Combined with the unclear and inconsistent communications to claimants on providing further evidence, this meant that claimants easily became confused and misled in relation to the amount of time available for gathering and presenting further evidence. Staff undertaking mandatory reconsiderations were focused upon processing decisions and did not seek out further evidence despite their responsibility to review decisions thoroughly and ensure all existing evidence was considered. Mandatory reconsideration decisions and their reasons were of poor quality.

A further revision stage operates following the submission of appeals. An appeals manager reviews the decision; if maintained, then it will be heard by a tribunal; if revised in the claimant's favour, then the appeal lapses. This stage is potentially beneficial to claimants given the anxieties of appearing before a tribunal. However, only limited information was provided to claimants about this stage. Many were unaware of and confused by the process and could not appreciate the difference between a further review and a tribunal appeal. The Department had not informed claimants of this additional review stage because it considered that doing so could be perceived as trying to dissuade claimants from appealing and also impact upon the statutory timeframes for lodging appeals. The Ombudsman found these justifications unpersuasive. Lapsed appeal revision decisions also relied heavily on pro forma pre-scripted statements. These features encouraged passivity and complacency by decision-makers concerning the quality of their decisions owing to the lack of input they had to perform. By not recording the reasons for their decisions or the evidence considered, case managers were unlikely to have properly and conscientiously considered all of the evidence or made robust decisions. There was often little real substantive engagement by appeal managers in making those decisions. The practices illustrate both the importance of reason-giving and how easily decision-makers can evade them in practice. As the Ombudsman noted, "the ramifications of incorrect and/or poorly explained decisions, go far beyond those claimants directly affected. They contribute to a much wider perception of an unreliable opaque process which is at odds with the principle of 'being open and accountable'".[48]

Nonetheless, it was only at this revision stage that further evidence was likely to be properly considered. The ability to review decisions was valuable, but there was "an over-reliance on repeat opportunities" within the process to review evidence and thereby ensure claimants received their correct entitlements.[49] This approach relied upon claimants challenging decisions and overlooked the extra time, frustration and anxiety involved both financially and in terms of the experience to claimants personally. This was a high-risk approach given that many claimants lacked support or the tenacity to challenge decisions and could therefore lose out on their entitlements.

[47] See generally R. Thomas and J. Tomlinson, "Mapping Current Issues in Administrative Justice: Austerity and the 'More Bureaucratic Rationality' Approach" (2017) 39 *Journal of Social Welfare and Family Law* 380, 391–394; R. Thomas and J. Tomlinson, "A Different Tale of Judicial Power: Administrative Review as a Problematic Response to the Judicialisation of Tribunals" [2019] *Public Law* 537.
[48] Northern Ireland Public Services Ombudsman, *PIP and the Value of Further Evidence* (2021), pp.21–22.
[49] Northern Ireland Public Services Ombudsman, *PIP and the Value of Further Evidence* (2021), p.246.

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Claimants could also complain about Capita assessments and the failure to collect further evidence. Public bodies should have good, fair and proportionate complaint systems.[50] However, there was "little evidence that the Department independently or robustly" investigated complaints.[51] In fact, the Department simply forwarded complaints against Capita to Capita and then relied upon its responses. Capita's standard line was that the decision whether or not to obtain further evidence was a clinical matter for the assessor. The Department accepted this without scrutiny. The Ombudsman found this inadequate and "unlikely to deliver meaningful outcomes and secure confidence in the administration of the PIP system".[52] Given that further evidence was a significant factor in the overturning of decisions and a persistent source of concern amongst stakeholders, the Ombudsman criticised the Department's failure to address the problem of further evidence through the complaints process. Indeed, that process failed to identify shortcomings at both individual and systemic levels. There were also significant weaknesses with the governance of complaints, the lack of a policy on complaints against Capita and on the recording and reporting of complaint outcomes.

The Ombudsman's final set of findings concerned the Department's statistics on the use of further evidence about claimants' conditions. There were significant weaknesses with these statistics, in particular the recording of the number of requests to gather further evidence. The Department's position was that decisions were overturned because "new" evidence had been provided which had been previously unavailable to initial decision-makers. However, the statistics used by the Department to sustain its position were flawed. The Department had not properly recorded the nature of the additional evidence and whether it had fact been new and previously unavailable. In many instances, the "new" additional evidence could have been obtained at earlier stages of the decision process but had not been sought or considered. Consequently, the Department's blanket reasoning that decisions are overturned because of new evidence was inaccurate and misleading. Furthermore, the failure to record why decisions were overturned at the mandatory reconsideration stage meant that the Department could not use its management information to identify learning to implement improvements. Instead, the Department had simply assumed that decisions were being overturned on the basis of "new" evidence when such evidence had been available from the outset of the process, but not requested. Capita had also miscalculated statistics on the use of further evidence thereby giving an inflated and inaccurate impression of how frequently its assessors requested further evidence from health professionals. Despite the Department's reassurance that the problem had been corrected, it had, in fact, continued to use the inaccurate statistics in its responses to FOI requests. The Department's inadequate monitoring of Capita's statistics was a significant governance failure. Overall, the Ombudsman found multiple instances of systemic maladministration.

Analysing and understanding systemic maladministration

The preceding discussion has looked downwards into the minutiae of the PIP assessment process and the Ombudsman's findings. We also need to look upwards and consider the matter from a higher altitude. By doing so, we can seek to understand how the Department came to operate a large-scale process designed to deliver benefits for vulnerable people which was characterised by multiple instances of systemic maladministration and which the Department itself was oblivious to. In this way, the Ombudsman's report raises general themes of administrative justice: the interactions between

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[50] Parliamentary and Health Service Ombudsman, *Principles of Good Complaint Handling* (2009); Northern Ireland Public Services Ombudsman, *Complaints Handling in the Public Sector in Northern Ireland* (2021).
[51] Northern Ireland Public Services Ombudsman, *PIP and the Value of Further Evidence* (2021), p.252.
[52] Northern Ireland Public Services Ombudsman, *PIP and the Value of Further Evidence* (2021), p.257. See also Northern Ireland Public Services Ombudsman, *Complaint against the Department for Communities* (21568, 2021) (poor and inadequate complaint-handling by the Department; no independent mechanism at senior level to review complaints).

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claimants and the Department and the latter's need for legitimacy. We have to examine the conundrum that the Department argued that the PIP decision process was legitimate even though it was characterised by systemic maladministration. Not only was the Department unaware of its failings, the systemic maladministration identified was deeply embedded within and indeed a product of its institutional culture. How could systemic maladministration become so normalised that it came to be seen as an entirely ordinary and non-problematic feature of the PIP process?

We can first consider people's interactions with the system and then approach matters of legitimacy and institutional culture. Seen from the claimant's perspective, this entire process is Kafkaesque. Claimants are often vulnerable people with health issues. They provided the details of their health professionals on the claim form but were specifically told not to collect evidence from health professionals and only provide what evidence they already have. Claimants may have assumed that their health professionals would be contacted by Capita/the Department, but this rarely happened. Claimants were left not knowing what, if any, further evidence has been requested and considered. This placed them at a "systemic disadvantage".[53] Claimants' experiences of assessments were largely negative.[54] Assessment reports were not automatically disclosed but had to be requested. Communications were confused and unclear. Decisions were taken by faceless case managers and not properly explained. There was unclear and confused advice about onward internal review processes.

What claimants did not know—but we do now—is what was happening behind the closed impersonal walls of administration. Assessors rarely requested further evidence because of the limited time at the initial review stage and the mentality of processing claims quickly and then moving on to the next one. Case managers overwhelmingly deferred to assessors because of time pressures. Decisions were poorly reasoned because of the inadequacies of the automated system. Complaints about Capita assessments were passed by the Department to Capita for responses. The overall picture suggests an overwhelmed, dysfunctional bureaucracy processing claims quickly to get through the caseload and thereby failing both to follow good administration and to award people their legal entitlements.

Viewed from a wider perspective, a core problem of administrative justice emerges: what makes administrative decisions legitimate? Any decision system must be perceived to be acceptable and legitimate, even though individual decisions may be erroneous and contestable.[55] There are various arguments for legitimacy that can be advanced. However, the benefit agency's quest for legitimacy is highly problematic.[56] Claimants have no choice between different providers. Their only choice is whether to claim benefits or not at all. There is a pervasive lack of claimant trust. The agency cannot assert its authority over people; its task is providing benefits to disadvantaged people not coercing them. The democratic connection is very tenuous. Parliament enacts the statutory frameworks of benefits, but implementation is undertaken by administrators distant from Ministers. This involves value judgements about system-design and delivery. The democratic connection is even more problematic in NI given the fragility of devolved government and the inherent constraints reflected in the principle of parity. These

[53] Northern Ireland Public Services Ombudsman, *PIP and the Value of Further Evidence* (2021), p.16.

[54] See generally House of Commons Work and Pensions Committee, *PIP and ESA Assessments: Claimant Experiences* (HC 355 2017–19); R. Machin and F. McCormack, "The Impact of the Transition to Personal Independence Payment on Claimants with Mental Health Problems" (2023) 38 *Disability & Society* 1029. The Ombudsman was concerned that assessors' informal observations were inappropriately treated as fact. In some cases, these observations were irrelevant to the claimant's reported difficulties, e.g. a decision letter referred to the claimant being able to walk unaided when the claimant's primary condition was schizophrenia and had not reported any physical restrictions (Northern Ireland Public Services Ombudsman, *PIP and the Value of Further Evidence* (2021), p.144). See also J. Pring, "PIP investigation: 200 cases of dishonesty … and still DWP, Atos and Capita refuse to act" *Disability News Service* 3 August 2017.

[55] Se generally J. Mashaw, *Bureaucratic Justice* (New Haven: Yale UP, 1983); M. Adler (ed), *Administrative Justice in Context* (Oxford: Hart, 2010).

[56] "Benefits agency" is used here as a generic label, although it obviously includes both the Department for Communities and the DWP.

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weaknesses are accentuated by the outsourcing of assessments which raises anxieties about profits being exalted over the public interest. Nor can the agency invoke expert professional knowledge as a legitimating value. Assessors are generalists, not specialist experts. Even if they were, the time pressures, incentive-structures and cultures in which they work would significantly militate against them functioning as such. Case managers are junior officials who process cases. Of course, professional judgement could be deployed as a legitimising value through the greater collection and use of further evidence from claimants' health professionals, but it was precisely this which the Ombudsman found to be largely absent.

Other legitimising values—human dignity and claimant participation—are largely undermined in practice. Assessments are hardly the type of encounters that promote human dignity, but more of an opportunity in which assessors (are perceived to) catch out claimants through informal observations.[57] Claimants have no direct interaction with case managers. Participation and independence are most evident at the tribunal stage, but many people do not appeal because of their anxiety and vulnerability. As the Ombudsman emphasised, relying upon tribunals raises the prospect that decision-makers will not take all best endeavours to get decisions right from the outset.[58] Efficiency is clearly desirable, but not to the extent that it undermines the quality of decisions.

In this context, a benefits agency is forced into a difficult position. It cannot credibly advance a strong normative argument for the acceptability of its decisions. What then does it do? The agency's most common response has been to adopt the defensive tactic of seeking legitimacy by attacking the criticisms levelled against it. Stakeholders frequently criticise the poor quality of initial decisions as evidenced by the high volume of successful appeals. The agency's response is two-fold. First, only a small proportion of claimants appeal. Secondly, appeals are overwhelmingly allowed because of new evidence that was previously unavailable. Accordingly, the headline figure of allowed appeals is not at all indicative of the overall quality of initial decisions.[59] By neutralising and undermining criticisms based upon appeal overturn rates, the agency seeks to maintain the legitimacy of its decisions. This approach is itself a weak tactic, an implicit recognition that the agency cannot make a positive affirmative argument for its legitimacy. However, the substance of the response has now been conclusively demonstrated by the Ombudsman to be flawed.

To understand how and why the Department came to rely upon such inadequate arguments to assert its own legitimacy, we need to consider the Ombudsman's wider findings concerning institutional culture, the principal determinant of administrative behaviour. A key theme of neo-institutional theory is that organisations are not just technical and rational systems for integrating means and end and transforming inputs into outputs.[60] Institutions are also influenced by the wider social and cultural forces about how to treat claimants and their deservingness. Highly conditioned by the wider environments in which they

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[57] The Ombudsman found that when assessors' informal observations were referenced in decision letters, it was not explained that they were observations from assessment consultations. It was often unclear what descriptor choices or activities the observations were being applied to in the reasoning behind the decision. In some cases, the observations included had no obvious relevance to the claimant's reported difficulties, e.g. a decision letter referred to the claimant as being able to walk unaided when the claimant's primary condition was schizophrenia. See Northern Ireland Public Services Ombudsman, *PIP and the Value of Further Evidence* (2021), p.144.

[58] Northern Ireland Public Services Ombudsman, *PIP and the Value of Further Evidence* (2021), p.25.

[59] These responses are frequently deployed by the DWP. The Department for Communities has also used them. e.g. when the investigation was announced, the Department noted that "only 12 complaint cases (0.006%)" had been formally referred back to the Department by the Ombudsman. This overlooked the extensive handling of complaints internally and their poor quality, which the Ombudsman criticised heavily. See "Department responds to Northern Ireland Public Services Ombudsman investigation" 24 June 2019. On the DWP, see E. Dugan, "A senior judge has suggested charging the government for every 'no-brainer' benefits case it loses in court" *BuzzFeed News* 9 November 2017.

[60] See generally W.W. Powell and P.J. DiMaggio (eds), *The New Institutionalism in Organizational Analysis* (Chicago: University of Chicago Press, 1991).

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operate, governmental institutions also generate their own internal cultures to make sense of their work and to deal with their caseloads. For the purposes of self-legitimation, these institutional cultures produce and reproduce their own myths and narratives. These myths and narratives are culturally constructed from the institutionalised environments in which a government agency operates and the interactions that take place within them. The myths come to be seen as a taken-for-granted objective reality, which then affect the behaviours of officials and the public. Accordingly, much of what is presented by institutions as rational behaviour is, in reality, a self-interested and post hoc claim of rationality to justify their actions in an acceptable way.[61]

The importance of these insights is illustrated by the Ombudsman's wider findings concerning the culture, mindset and embedded thinking within the PIP system. The Ombudsman had found that "built into the system and culture" was an accepted and taken for granted set of assumptions.[62] Further evidence should have been gathered by claimants, even though they were told not to collect it. Alternatively, such evidence could be gathered "later on" in the process. Decision-makers were focused upon processing decisions on the basis of whatever information was available, even when it was clearly incomplete, and then moving on to the next claim. The burden was then placed upon claimants to keep challenging decisions throughout the process despite them not knowing what evidence had been considered. When decisions were later overturned, the Department rationalised this on the ground that "new" evidence had been provided that was previously unavailable. The Department drew upon its limited analysis of the reasons why decisions were overturned to confirm that there was no poor-quality decision-making because decisions were only changed when claimants provided "new" evidence presented later in the process. These institutional myths, constructed within and by the Department, had become so deeply embedded that they were accepted as objective facts. Accordingly, for the Department, there was no systemic maladministration.

The Ombudsman exposed the fallacy of these self-serving myths. It was incorrect to state that decisions were overturned because of "new" evidence. Such evidence was available from the very outset but had not been requested or considered by decision-makers. While both the Department and Capita contended that further evidence played a key role in the process, this was at odds with reality. Neither had properly discharged their responsibility to obtain such evidence from the outset. The Department's flawed analysis that initial decisions were overturned because of "new" evidence had provided an "inaccurate reassurance to the public" that its internal workings were precise and robust whereas in fact they were not.[63] This "line of thinking" that had "been simply accepted by the Department as a fact outwith its control".[64] The "simple narrative" that there was no maladministration in the system was itself "likely to perpetuate rather than rectify" that maladministration.[65]

The Department's myths were an illusion of rationality generated by its own culturally determined assumptions, the pressures of its operating environment and the need to project a vision of its legitimacy and its institutional culture. The Ombudsman's findings here are crucially important in terms of understanding how the Department constructed simple scripts and narratives which it then treated as objective reality and sought to convince others likewise. The effect was that the system had simultaneously generated systemic maladministration while enabling the Department and Capita to deny it. Both were, of course, entirely unconscious of this because the assumptions were deeply embedded within the culture and mindset of the system. The major contribution of the Ombudsman in this respect was its ability to identify and expose the flaws of the Department's institutional myths constructed by its internal culture and which it had then used to legitimise itself. The Ombudsman had

[61] R.L. Jepperson and J.W. Meyer, *Institutional Theory: The Cultural Construction of Organizations, States and Identities* (Cambridge: CUP, 2021).
[62] Northern Ireland Public Services Ombudsman, *PIP and the Value of Further Evidence* (2021), p.16.
[63] Northern Ireland Public Services Ombudsman, *PIP and the Value of Further Evidence* (2021), p.16.
[64] Northern Ireland Public Services Ombudsman, *PIP and the Value of Further Evidence* (2021), p.16.
[65] Northern Ireland Public Services Ombudsman, *PIP and the Value of Further Evidence* (2021), p.25.

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exposed the flaws within the Department's purportedly "rational" approach which were little more than self-serving myths constructed to deflect criticisms that its decision-making was illegitimate. This finding confirms the importance of the independent and external scrutiny provided by the Ombudsman's own-initiative investigation into not just surface-level problems, but also the institutional culture of a system which simultaneously generates those problems and make them invisible.

Conclusion

The Ombudsman's PIP report is important in various respects. There has been no equivalent investigation of such depth and detail into PIP or any other social security benefit or indeed almost any other part of government. The report was based upon extensive empirical data and contained multiple detailed findings. It was a detailed exercise in administrative accountability. It was extremely difficult for the Department to contest the Ombudsman's findings and indeed, it subsequently accepted all of them bar one.[66]

Putting the detail of specific findings to one side, the Ombudsman's wider findings were especially important in getting to the core of the underlying institutional-cultural dysfunctionality of the PIP system. The report also represented a significant exercise in collective justice. The investigation undertook a global and grass-roots up examination and scrutiny. The Ombudsman uncovered the behavioural realities of government, its outsourced provider and how claimants interacted with the process. It repeatedly emphasised that many claimants simply give up and do not challenge decisions. The Department knew this. Nonetheless, it tolerated an extensive degree of poor-quality decision-making and indeed explained away the existence of the systemic failures for which it was responsible. The Ombudsman also challenged the Department to reflect comprehensively on how it could improve. These features go far beyond the limited focus of individual redress, such as complaints and tribunals, which typically decide cases one at a time without any consideration of the underlying causes of poor decisions.

However, we have only considered half of the problem. The Ombudsman's report made detailed and extensive findings of systemic maladministration, a crucial first step, but "only the start of the process to put things right and crucially get it right for the future".[67] The purpose of collective justice mechanisms, such as own-initiative investigations, is not just to identify diagnose institutional failings and identify wide-scale injustice, but also to change things for the better. The strength and cogency of the Ombudsman's findings do not, of course, make the task of changing institutional culture and mindset any easier, although identifying these cultural and mindset problems is a prerequisite in order to make progress. From the outset, the Ombudsman had intended that the investigation would generate "recommendations with real and meaningful impact".[68] Yet, the report itself at one point struck something of a discordant note. The Ombudsman highlighted that the Department's reported implementation of some recommendations from previous reviews had been "superficial and unlikely to have impact".[69] This raises two large questions. How would the Department respond to the Ombudsman's recommendations? And, more generally, when systemic maladministration has been identified, not just at the surface level, but deep within the culture and thinking within government, what realistically can be done to address it? We must therefore examine the Ombudsman's

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[66] The Department rejected the Ombudsman's finding that appeal case managers did not, at the lapsed appeal stage, explain their decisions properly: Northern Ireland Public Services Ombudsman, *PIP and the Value of Further Evidence: Follow Up Report* (2023), p.61.
[67] Northern Ireland Public Services Ombudsman, *PIP and the Value of Further Evidence* (2021), p.42.
[68] Northern Ireland Public Services Ombudsman, *PIP and the Value of Further Evidence* (2021), p.40.
[69] Northern Ireland Public Services Ombudsman, *PIP and the Value of Further Evidence* (2021), p.28.

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recommendations, the Department's response and its progress in implementing them. That is the task of Pt 2.

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