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AFRICAN OMBUDSMAN RESEARCH CENTER - WEBINAR ON SYSTEMIC INVESTIGATION

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What is a Systemic Investigation?

- Issues, authorities and scope of investigation indicative of a pattern that negatively affect more than an individual complainant.
- Often, systemic problems in Department or Ministry structure, policies, procedures or practices are
 - o uncovered during preliminary investigations of individual complaints
 - o alleged or identified by individual complainants
 - evident from media hype N.B. prior to financial crisis of 2007, Quebec
 Ombudsman had assigned a part-time staff member to peruse the media / listen to talk-shows
- S. 5 of the Bermuda Ombudsman Act: The functions of the Ombudsman are 1(b) pursuant to an investigation, to make recommendations to the authority concerning any administrative action that formed the subject of the investigation and, generally, about ways of improving its administrative practices and procedures
 - 2(b) on his own motion, notwithstanding that no complaint has been made to him, where he is satisfied that there are reasonable grounds to carry out an investigation in the public interest
- As many as 87% of Ombudsman have the power to launch investigations on their own motion / initiative. Some require that a relevant complaint must first be lodged before the Ombudsman may exercise discretion to undertake a systemic investigation
- Distinguish Systemic Investigations from Systemic Recommendations
 - o General recommendations arising from individual complaint investigation
 - Recommendation that Department itself conduct systemic review (e.g. Department of Education re services and accommodations for all Special Needs students)
- Ombudsman discretion to undertake Systemic Investigations is exercised with care
 - Undertake only if criteria are clear and persuasive that the Ombudsman recommendations could lead to continued or high value service improvements
 - Ombudsman decision to exercise discretion also cognizant of resource efficiency as such investigations resource intensive esp. for small or underfunded offices

- Some larger offices have designated team or process to corral internal resources for systemic investigations, notably Ombudsman Ontario – SORT (Special Ombudsman Response Team) + additional staff assigned as needed
- A Systemic Investigation need not always entail large time or staff commitment:
 Barbados 1999 the Ombudsman investigated complaints that public beaches were not accessible due to private beachfront property owners erecting barriers to access paths.
 He held a highly publicized "South and West Coast Walk" with media in tow to see where he could actually access the beaches. Recommended reinstallation of public access corridors.

What criteria warrant a Systemic Investigation

- Systemic investigation may be triggered by a matter that is sensitive or high-profile /
 of wide public interest and debate or involves an important public institution or event
 - Report: "Today's Choices Tomorrow's Costs" dealt with approval by the Minister of a major hotel development on land that had previously been protected environmentally and was located in the last, most pristine and biodiverse area of the island. Investigation was not of the Minister's actual decision, but of the information provided to him by the Department of Planning. Investigation found that no Environmental Impact Assessment was required: contrary to an Environmental Charter that Bermuda had signed with the UK that required EIA for development proposals that are 'major' or 'likely to have severe adverse effect on the environment'; and, inconsistent with global EIA standards and Privy Council decisions
 - O Report: "A Tale of Two Hospitals" investigated claims of racism by the then White hierarchy within the hospital against Black doctors that had bubbled up periodically in the media over the years without ever being formally addressed. There is only one hospital in Bermuda and such negative media fed a lack of public confidence. The investigation found: differential treatment of complaints against Black and White doctors; poor mortality and morbidity clinical incident review process; inadequate policies for appointments of heads of medical practices; and, a lingering reflection and legacy within the hospital of the island's history of systemic racism
 - Report: "4 x 6 = 262" arose from media reports. The investigation dealt with an inadequate Request for Proposal and decision process for the development of the waterfront of Bermuda's capital city which would have been the most significant and high cost development in Bermuda requiring a 262 year lease for developers. The RFP process was a 4 inch by 6 inch advertisement placed for 3 days in the newspaper without briefing pages of specifications or meetings with prospective developers that is typical of RFPs for such major proposals. The RFP decision process was not only contrary to Bermuda RFP practices for other developments, international best practices for waterfront

developments, but was also contrary to the city's own practices for previous RFPs for other developments.

- Matter spans several Ministries and/ or Departments
- Repeated, persistent similar complaints demonstrating a systemic pattern or trend affecting multiple people
- Apparent root causes of complaints / concerns is system itself: structure, policies, procedures or practices
 - o rather than maladministration by individual civil servants
 - civil servants feel bound (by practice or guidelines) to take actions or make decisions that are inherently unfair, inefficient, arbitrary, unreasonable or mistake of facts
 - Issues are complex, multiple, severe / go beyond or transcend any one individual complainant / Facts are complex, highly technical and / or not agreed upon
 - Ombudsman Ontario SORT announces launch of an investigation then requests the public to contact them if they have similar concerns; dedicated telephone intake team; reassign regular staff as needed
- No other authority has the jurisdiction or can readily investigate
 - e.g. not criminal within the jurisdiction of the police; Department of Public Prosecutions; or other authorities such as the Human Rights Commission
 - e.g. Tale of Two Hospitals first checked on whether the Human Rights
 Commission could investigate which has racism within its remit; indicated
 that a broad systemic investigation was not within their jurisdiction; indeed
 had they had referred one of the complainants to the Ombudsman
 - Note: Preliminary Assessment: two separate Medical Associations – one Black, the other White: prima facie evidence of a racial divide
- At request of Government, Ombudsman may exercise discretion to review internal or other systemic reports
 - E.g. Review of Clinical and Corporate Governance Review commissioned by Government in order to assure the public of independence of review (i.e. public skeptical that consultants hired by the hospital would recommend what the hospital wanted to do rather than what should be done). Finding: Consultant's recommendations vague – pitching for further contract
- Fear of retribution; prevention of arbitrary decision-making
 - o Report: "Atlantica Unlocked" investigated complaints from several repeat researchers who alleged that the Archivist leader treated the national holdings as her private preserve, assisting research that she thought was worthy and undermining staff capacity to assist researchers. Because their academic work

or livelihoods depended on continued access to the Archives the researchers feared being identified as complainants; National Archives only repository of island's history – intact and unbroken since 1625

- Note: Investigation plan entailed a Preliminary Assessment tests to substantiate complaints before proceeding to in-depth investigation of policies and practices: could not easily locate items listed in the Finding Aids inconsistent with global standards/ conversely, items in the Archives not mentioned in the Finding Aids that researchers must first consult
- An important trigger: ssues not amenable to an informal resolution process.

Value of / Lessons from a Systemic Investigation

- Usually formal report: eye-catching cover and title compels attention and responsiveness of authorities and media; justifies Ombudsman use of resources
- Assists Government by identifying root cause thereby leading to recommendations that can change systems enough to prevent recurrence of maladministration
- Ensures accountability at the level of Department or high-level decision-makers, not just the civil servants who had interacted with / conveyed responses to complainants
- Ensures transparency of processes and criteria deployed by Department and/or Ministry and in doing so, explain operations of Department to the public
- Precludes repeated individual investigations of similar complaints and same witnesses
- Demonstrates good governance standards; national and international Best Practices
- Those Ombudsman who are also designated as National Preventative Mechanisms by their governments (to conduct annual reviews of places of detention) can establish the proactive role of the Ombudsman; and, augment and extend investigation methodology to other systemic issues
- Protects whistle-blowers
- Focus on vulnerable populations
 - who are not inclined to complain individually (e.g. 1st generation immigrants in UK)
 - Senior nursing home residents
 - o Poor, voiceless people

- Maintains a long-term "watching brief" to follow up on recommendations that may more take time to implement than required for addressing an individual complaint recommendation
- Creates a common record (historical or from multiple Departments / Ministries)
 - E.g. "A Grave Error": Government failed to protect the gravesite within a golf course that was the remaining remnant and legacy of an historical, independent Black community from whom land was taken in 1920 for White hotel development. The investigation pulled together oral histories from various descendants; documents, maps, interviews (including the last living witness) into one repository. Seven years later, there is now a Historic Land Loss Commission in Bermuda that is relying on the research conducted / and appendices gathered by the investigation
- Demonstrates independence of the Ombudsman
- Identifies corruption for potential criminal referral
- Identifies systemic discrimination, human rights abuses and constitutional breaches (e.g. *A Tale of Two Hospitals*; differential policing in Northern Ireland)
- During COVID: identifies and monitors e.g. short-cuts in processes (Wales re homeless criteria); power grabs (statutory meetings British Columbia); and, failure of transparency re data-gathering (EU); emergency funds (Malawi).

Note: small or under-funded offices that cannot support a designated Systemic Investigation team (such as SORT at Ombudsman Ontario) can deploy resources efficiently by:

- Short term consultants for technical review. E.g. for A Tale of Two Hospitals, I employed several consultants (see Process Appendix) such as a coroner to review the clinical rationales for apparent disparate treatment of complaints against Black and White doctors. However, the cost of consultants is often in the hours they consume prepare reports. So instead, I developed a process to save that expense:
 - o asked consultant for a one or two page written summary of conclusions
 - o used this to question consultants in an extensive conversation, taking copious notes
 - o drafted the information / findings I needed from the consultant for the report
 - o then checked with consultant who gave written confirmation that my draft was accurate.
- Hiring temporary document management / proof-reading staff for duration of each systemic investigation, freeing permanent to staff to focus on investigation and their regular ongoing duties.
- Maintaining a evidence binder for the final report each sentence / paragraph / assertion in the report must be substantiated by evidence. The Evidence Binder –

copied or specifically referenced source of the evidence. We held an all-staff meeting where my staff challenged each sentence (playing the role of a defensive recipient of the report)

• Final proof-reading was done by two team (one senior / one more junior) – reading the report out loud to check for errors and sense. The goal was to ensure that junior staff found it intelligible and engaging – then we could hope that the general public would also.

See www.ombudsman.bm/publications/systemicinvestigationreports

A TALE OF HOSPITALS

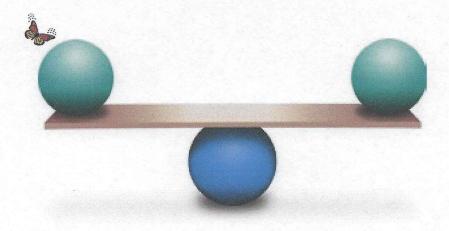
Who Gets The Benefit Of The Doubt?



The Ombudsman for Bermuda's Own Motion Systemic Investigation into Allegations of Discrimination Involving Medical Professionals at King Edward VII Memorial Hospital



November 2007



Today's Choices Tomorrow's Costs

The Ombudsman for Bermuda's Systemic Investigation into the Process and Scope of Analysis for Special Development Orders



February 10, 2012



A GRAVE ERROR

The Ombudsman for Bermuda's Own Motion Investigation into the Demolition of Tombs in the Marsden Methodist Memorial Cemetery at Tucker's Point



January 2014

