

**Investigation of a complaint against the Western Health & Social Care Trust**

**Report Reference:** **202005550**

The Northern Ireland Public Services Ombudsman

33 Wellington Place

BELFAST

BT1 6HN

Tel: 028 9023 3821

Email: nipso@nipso.org.uk

Web: [www.nipso.org.uk](http://www.nipso.org.uk)

**The Role of the Ombudsman**

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

You should normally complete the complaints procedure of the organisation concerned. The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

**Reporting in the Public Interest**

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

|  |  |
| --- | --- |
| **TABLE OF CONTENTS** | **Page** |
| SUMMARY ……………………………………………………… | 4 |
|  |  |
| THE COMPLAINT ………………………………………………. | 5 |
|  |  |
| INVESTIGATION METHODOLOGY …………………………. | 6 |
|  |  |
| THE INVESTIGATION …………………………………………. | 7 |
|  |  |
| CONCLUSION …………………………………………………... | 15 |
|  |  |
| APPENDICES ……………………………………………………. | 17 |
| Appendix 1 – The Principles of Good Administration |  |

**Case Reference: 202005550**

**Listed Authority: Western Health and Social Care Trust**

# SUMMARY

The complaint concerned the actions of the Gateway Team at the Western Health and Social Care Trust (the Trust). The complaint related to the Gateway Team’s handling of the complainant’s referral about the emotional and mental health of his two children.

The investigation found, in considering the referral made to Social Services by the complainant, the Trust did not act appropriately and in accordance with its statutory responsibilities, relevant legislation, procedures and standards.

The investigation found the Social Worker should have made more attempts to speak with the complainant to understand his concerns before closing the referral. The investigation also found the Trust did not have sufficient detail regarding the concerns to determine the allegations did not meet the threshold for Initial Assessment. It found the Trust focused too heavily on the contact aspect of the concerns raised. The investigation further found the Trust’s decision to complete individual work with the children upon receipt of the original complaint, and some months after it had closed the referral, lacked an appropriate rationale and should not have been completed at that time. Additionally, it found the work with the children focussed on contact and did not explore the complainant’s other concerns.

I recommended that the Trust apologised to the complainant for the failures identified and made recommendations to prevent recurrence. I recognised the failures caused the complainant to lose confidence in the Trust’s preparedness to take his concerns about his children seriously.

# THE COMPLAINT

1. This complaint was about the actions of the Western Health and Social Care Trust (the Trust) and how its Gateway Team[1](#_bookmark0) dealt with the complainant’s referral about the emotional and mental health of his two children.

**Background**

1. On 13 May 2023 the complainant contacted Family Support Northern Ireland (FSNI)[2](#_bookmark1), stating his children were going through ‘*the worst case of parental alienation*’, that their mother was controlling, and he was concerned about the children’s mental health. He said that he had not seen his children for eleven months. The FSNI passed this information to the Trust’s Gateway Team on 15 May 2023.
2. The allocated Social Worker attempted to contact the complainant on two occasions, namely, 16 and 17 May 2023, but was unable to get through. After speaking with the children’s mother on 16 May 2023, Social Services determined no further action was needed on their part because the issues raised were about contact and a court order was in place for this. Social Services wrote to the complainant on 22 June 2023 to confirm the case was closed. The Social Worker subsequently completed individual work with the children on 10 August 2023, following receipt of the complainant’s written complaint on 28 June 2023.

**Issue of complaint**

1. I accepted the following issue of complaint for investigation:

**Issue 1: Whether the Trust’s Gateway Service addressed concerns the service user raised on 13 May 2023 about the emotional and mental health of his children, in accordance with relevant guidance and procedures.**

In particular this considered:

* + the closure of the case without input from the complainant;
	+ the decision not to conduct an initial assessment; and

1Gateway is a Social Work Service for children and families. They are the first point of contact for children and young persons in need of assistance or support.

2 Family Support Northern Ireland provides information on a wide range of family support services and registered childcare provision in Northern Ireland

* + the meeting Trust staff undertook with the children on 10 August 2023 after the service user’s written complaint of 28 June 2023.

# INVESTIGATION METHODOLOGY

1. To investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Trust’s complaints process.

**Independent Professional Advice Sought**

1. After further consideration of the issues, I obtained independent professional advice from the following independent social work advisor (ISWA):
	* **Social Worker**, BA. (HONS), C.Q.S.W, Dip Applied Social Studies, Social Work Practice Teaching Award, with 35 years’ experience in Child Protection.

I enclose the clinical advice received at Appendix two to this report.

1. The information and advice which informed the findings and conclusions are included within the body of this report. The ISWA provided ‘advice’. However, how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

**Relevant Standards and Guidance**

1. To investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional, and statutory guidance.

The general standards are the Ombudsman’s Principles[3](#_bookmark2):

* + The Principles of Good Administration

3 These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

1. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

The specific standards and guidance relevant to this complaint are:

* + The Department of Health’s Understanding the Needs of Children in Northern Ireland June 2011 (UNOCINI guidance);
	+ Northern Ireland’s Social Care Council’s Standards of Conduct and Practice, August 2019 (NISCC standards); and
	+ The Department of Health’s Co-operating to Safeguard Children and Young People in Northern Ireland August 2017.

I enclose relevant sections of the guidance considered at Appendix three to this report.

1. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.
2. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. Both the complainant and the Trust accepted my findings.

# THE INVESTIGATION

**Whether the Trust addressed concerns the service user raised on 13 May 2023 about the emotional and mental health of his children, in accordance with relevant guidance and procedures.**

In particular this considered:

* + the closure of the case without input from the complainant;
	+ the decision not to conduct an initial assessment; and
	+ the meeting Trust staff undertook with the children on 10 August 2023 after the service user’s written complaint of 28 June 2023.

**Detail of Complaint**

1. The complainant said that the Gateway Team did not consult with him regarding his concerns and closed the case following its conversation with the children’s mother. He explained he missed two phone calls, due to being on holiday, however the Trust closed the case without his input. The complainant said Social Services did not gather all information prior to closing the case.
2. The complainant also said that the Gateway Team did not complete a thorough assessment of the concerns he raised. He explained he contacted the FSNI on 13 May 2023 and told them he had not seen his children for 11 months. He explained the children were going through ‘*the worst case of parental alienation imaginable*’, that they ‘*seem terrified of their very controlling mother*’, that they have been *‘poisoned against him’* and he was ‘*very worried about their mental health*’. He requested Social Services Intervene, and considered the Trust should have conducted an assessment into these concerns.
3. The complainant said the Trust advised him in its complaint response that as he did not respond to the Social Worker’s attempted contacts to discuss his concerns, it closed the case. He explained, however, following this closure, the Trust went on to complete individual work with the children. The complainant questioned the individual work the Trust completed with the children and considered the Trust’s response focused on the mother’s perspective rather than the children’s.

**Trust’s response to investigation enquiries**

1. The Trust stated given the limited information the complainant provided, it took steps to gain a better understanding of what his concerns were. The Social Worker attempted ‘*multiple times*’ to make contact with the complainant to discuss his concerns with him directly and, to date, it received no follow up calls from him.
2. The Trust stated given the Gateway Service’s limited timeframe to hold on to a case, it was important for the Social Worker to speak with the children and decide whether this case met the threshold required to undertake an initial assessment.
3. The Trust stated given the difficulties experienced in getting in touch with the complainant, the Social Worker was not able to discuss the steps the Gateway Service took at that time to address his concerns. Therefore, it sent a detailed letter to his home address.
4. The Trust stated an Initial Assessment is necessary when children are potentially deemed to be in need or at risk. It explained in this case, it determined the issue related to contact between the children and their father, which the Court had already ruled on.
5. The Trust stated based on the referral information the complainant provided, it decided the threshold for a full Initial Assessment was not met. The Social Worker decided to meet with the children as part of the enquiry process given the complainant’s worries, and to ensure that they had an opportunity to speak with a social worker to discuss their emotional wellbeing. The Trust explained it was also important to ascertain if an Initial Assessment was required. Following this contact, the Gateway Team decided to close the enquiry.
6. In response to further enquiries made during the Investigation, the Trust confirmed it decided to meet with the children on 10 August 2023 following receipt of the complainant’s written complaint and review of the initial referral process.
7. The Trust acknowledged in its response to my Office it could have written to the complainant to seek further information from him when it was unable to reach him by telephone. It accepted this would have given the complainant the opportunity to provide any additional clarification or information about his concerns, and have his views and opinions included in its decision-making. The Trust stated it will apply this learning in its future practice.

**Documentation and records I examined**

1. I completed a review of the copy documentation the complainant provided, and those the Trust provided in response to my investigation enquiries. I outlined my consideration of this evidence in my analysis and findings below.

**Relevant Independent Professional Advice**

1. I enclose the ISWA’s full advice at Appendix two to this report. I outlined my consideration of the advice in my analysis and findings below.

**Analysis and Findings**

1. I carefully examined the Trust’s actions and decisions in dealing with the complainant’s referral in May 2023.

*The closure of the case without input from the complainant*

1. The complainant said Social Services should have spoken with him before closing the case. I reviewed the Social Work records and note the Gateway Team received the complainant’s concerns on 15 May 2023 from the FSNI.
2. Records show the allocated Social Worker attempted to contact the children’s mother via telephone on 15 May 2023, and she returned this call on 16 May 2023. I reviewed the record of this call and note the Social Worker only discussed contact between the children and the complainant and the existing court order. There is no evidence to demonstrate or suggest the Social Worker discussed the complainant’s concerns about the children’s emotional and mental health, or the allegation the children were ‘*terrified*’ of their mother.
3. It is unclear why the Social Worker contacted the mother first, following receipt of the referral, rather than the complainant, who made the referral. I note that UNOCINI guidance states ‘*in most circumstances, a discussion should be undertaken with the* ***referrer*** [my emphasis] *to obtain clarification of details. Ideally, this discussion would occur prior to first contact with the child/family*’.
4. I note the Social Worker recorded their attempts to call the complainant on 16 and 17 May 2023 and the voicemails they left. Records show the Social Worker sought advice from the Social Work Manager, and they agreed to close the case as the Trust ‘*cannot go against court order*’.
5. The ISWA advised the complainant’s concerns were not specific and did not provide examples to evidence his assertions. He advised due to the broad nature and seriousness of the concerns raised, the Social Worker was unable to determine whether the referral was appropriate or otherwise without speaking to the complainant to explore his concerns in more detail. He advised the Trust should have made sure to contact the complainant before deciding whether an initial assessment was necessary. He further advised when the Trust was unable to contact the complainant by phone, it should have written to him and asked him to contact the Social Worker. Having reviewed all relevant records and standards, I accept this advice.
6. NISCC standards state Social Workers must ‘*strive to establish and maintain the trust and confidence of service users and carers*’. I consider the complainant likely felt dismissed by the Trust as a result of its actions. I further consider that by closing the case without speaking to the complainant or inviting re-contact, the Social Worker failed to adhere to these standards.
7. NISCC standards also state Social Workers *‘must be able to assess needs, circumstances, rights strengths and risks in partnership with those involved and respond appropriately’.* I consider the complainant was not managed in accordance with this standard, and that the response provided when the referral was closed was not appropriate as it did not address all concerns raised by the complainant.
8. I consider this failure caused the complainant to sustain the injustice of upset, uncertainty and frustration regarding the Trust’s handling of his concerns and the decision it made. The complainant also lost the opportunity to support the concerns he raised and to participate in the Trust’s decision-making process.
9. I therefore uphold this element of the complaint.

*The decision not to conduct an Initial Assessment*

1. I note the Social Worker wrote to the complainant on 22 June 2023 to advise the children were safe in their mother’s care and not being influenced. It informed him the mother was ‘*more than happy*’ to arrange contact, and that as contact was court directed, he should seek legal advice. It informed him there was ‘*no role for Gateway*’ and the case was closed.
2. The Co-operating to Safeguard Children and Young People guidance states ‘*HSCT Gateway Service will carry out an initial assessment using all the available information and decide if further action is required*’.
3. The UNOCINI Guidance states that, on receipt of a referral, the Initial Assessment will be completed. I note that the purpose of this Initial Assessment is ‘*to provide a timely overview of current circumstances*’ to enable appropriate decision-making about the level of service and intervention required going forward. Possible future actions include the provision of statutory social services support and intervention, referral to another agency or case closure.
4. Following a request for further information regarding the criteria it applied when determining that an Initial Assessment was not necessary, the Trust advised ‘*in this case it was determined that the issue was in relation to contact between the children and their father which had already been before the court*’.
5. As established earlier in this report, there is no evidence to demonstrate or suggest the Trust addressed or considered the complainant’s concerns about the children’s emotional and mental health, or the allegation the children were ‘*terrified*’ of their mother, when making its decisions. I consider this included when the Trust considered whether to undertake an Initial Assessment under the UNOCINI Guidance.
6. The ISWA advised the criteria the Trust applied and considered to determine whether the threshold for Initial Assessment was met or not should have been transparent. He advised custom and practice was for the Social Worker to detail the grounds for determining whether an Initial Assessment was required in the social work records and to document their decision. However, the Social Worker focused too heavily on the contact aspect of the referral and the court order when determining that the threshold for an Initial Assessment had not been met. He advised that, as a result, the Trust failed to demonstrate it considered each element of the complainant’s referral. Having reviewed the social work records, I accept this advice.
7. The ISWA advised there are circumstances where it would be deemed an Initial Assessment is not necessary. These include:
* where there is no significant risk of harm to the child or evidence that their needs are not being met. The ISWA advised the Trust could not have applied this criterion as there was not enough information within the referral to determine the children were not at risk or their needs were being met.
* if the Trust has recently completed a previous comprehensive assessment and there had been no significant changes in the child’s circumstances. The ISWA advised the Trust could not use this criterion to determine an Initial Assessment was not necessary because the most recent Initial Assessment completed was five months prior, and this wasn’t a full assessment.
* If the child’s needs can be met by other services without the need for Social Worker Assessment. The ISWA advised Social Services would not have known this when it received the referral and therefore this criterion could not be used to determine an Initial Assessment was not necessary.
* If the child’s parents do not consent to an Initial Assessment. In this case the father made the referral and requested an assessment. The Trust did not explore consent with the mother. The ISWA advised this criterion could not be used either.
1. The ISWA advised that on the face of it, the Trust did not have enough information in the referral to support the decision not to complete an Initial Assessment. Having reviewed all relevant evidence, I accept this advice. I consider the Trust did not take sufficient steps to gather all potentially relevant evidence to enable it to make its decision. Furthermore, it failed to demonstrate what, if any, consideration it gave to relevant criteria when making its decision, based on the evidence it did have.
2. NISCC standards state that Social Workers should ‘*maintain accurate, complete, retrievable and up to date records that comply with applicable legal and organisational requirements*’. From the records I have reviewed, I do not consider the Social Worker sufficiently documented the rationale for determining an Initial Assessment wasn’t required in this case.
3. I note the Trust’s initial position that it spoke to the children prior to deciding to close the case. However, having reviewed all relevant documents, there is no record of this taking place. I asked the Trust to provide additional evidence to support its position on this, and was advised the decision to meet with the children was made following receipt of the complaint. It is unclear why the Trust initially advised my Office that the decision took place before the referral was closed, and following meeting with the children, the decision was made to close the referral.
4. Principle three of the Principles of Good Administration, being open and accountable, states that public bodies should give information and advice that is clear, accurate, and complete. I do not consider the Trust has acted in accordance with this Principle when explaining its decision making to my Office.
5. I consider the failures identified caused the complainant to suffer the injustice of uncertainty and frustration regarding both the Trust’s decision not to complete an Initial Assessment and how it communicated its decision to him.
6. I uphold this element of the complaint.

*The meeting Trust staff undertook with the children on 10 August 2023 after the service user’s written complaint of 28 June 2023.*

1. From the initial records provided I was not able to ascertain when or why the Trust decided to meet with the children on 10 August 2023.
2. Having requested further information from the Trust during the course of this investigation, it has advised that the decision to meet with the children was made ‘*following receipt of the complaint and review of the initial referral process*’.
3. The UNOCINI guidelines state children should be seen for completion of the Initial Assessment. However, the Social Worker determined this case did not meet the threshold for an Initial Assessment. The ISWA advised that if the Initial Assessment threshold was not met, the children should not have been engaged. Having reviewed the guidelines and records available, I accept this advice. I find the decision to meet with the children following closure of the referral was not appropriate.
4. The ISWA considers it ‘*would not be usual to go back and speak to the children involved because a complaint had been received’*. Additionally, the further information provided by the Trust does not suggest that the complainant, who was also the children’s father and had made the initial referral, was contacted prior to the completion of the Individual Work, or upon the decision being made to speak with the children. As such, the ISWA considers the Trust’s decision to complete Individual Work with the children at that time was *‘procedurally incorrect’.* I accept this advice.
5. The ISWA considers there is lack of rationale for speaking with the children at the point the complaint was made, as the referral was closed at that time and an Initial Assessment was not considered to be required at that time. I accept this advice.
6. NISCC standards state Social Workers should *‘work within the legislative and policy context for social work, including professional codes, standards, frameworks and guidance’.* For the reasons outlined, I do not consider the Trust adhered to this

standard in relation to its decision to meet the children following the receipt of the complaint.

1. NISCC standards also state Social Workers must be accountable for the quality of their work, including *‘maintaining clear and accurate records as required by procedures’.* Principle 3 of the Principles of Good Administration; Being Open and Accountable, states that ‘public bodies should create and maintain reliable and usable records as evidence of their activities’. As there are no records to demonstrate why the Social Worker decided to complete individual work with the children at the time they did, I do not consider either the NISCC standards or the Principles of Good Administration have been adhered to.
2. I consider this failure caused the complainant to sustain the injustice of confusion, uncertainty and frustration regarding the Trust’s handling of his concerns and the decision it made to speak with the children following receipt of the complaint. The complainant is also likely to have lost trust in the Social Work team as a result of the lack of communication and lack consistency in the Trust’s approach.
3. I therefore uphold this element of the complaint.

# CONCLUSION

1. I received a complaint about the actions of the Gateway Service at the Western Health and Social Care Trust. In particular about how it dealt with the complainant’s referral concerning his two children. I upheld the complaint for the reasons outlined in this report. I consider this constitutes maladministration.
2. I recognise the failures caused the complainant upset, frustration and uncertainty, regarding the Trust’s preparedness to take his concerns about his children seriously. Additionally, the Trust’s failure to follow appropriate guidance and standards has caused the complainant the additional time and trouble to raise his concerns to my Office.

**Recommendations**

1. I recommend the Trust provides to the complainant a written apology in accordance with NIPSO’s ‘Guidance on issuing an apology’ (July 2019), for the injustice caused as a result of the maladministration identified (within one month of the date of this report).
2. I recommend the Trust provides training for all relevant staff on the requirements of the UNOCINI guidance.
3. I further recommend the Trust considers the internal guidance available to Social Workers when determining whether the criteria to complete an Initial Assessment is met. In addition, I recommend the Trust keep records to show its full consideration of guidance and criteria applied to support decision making.
4. I recommend the Trust considers its procedure regarding contacting referrers to ensure they are given the opportunity to provide further information where appropriate.

**MARGARET KELLY**

**Ombudsman**

**February 2025**

**Appendix 1 - PRINCIPLES OF GOOD ADMINISTRATION**

**Good administration by public service providers means:**

1. **Getting it right**
	* Acting in accordance with the law and relevant guidance, with regard for the rights of those concerned.
	* Acting in accordance with the public body’s policy and guidance (published or internal).
	* Taking proper account of established good practice.
	* Providing effective services, using appropriately trained and competent staff.
	* Taking reasonable decisions, based on all relevant considerations.
2. **Being customer focused**
	* Ensuring people can access services easily.
	* Informing customers what they can expect and what the public body expects of them.
	* Keeping to its commitments, including any published service standards.
	* Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances.
	* Responding to customers’ needs flexibly, including, where appropriate, co- ordinating a response with other service providers.
3. **Being open and accountable**
	* Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
	* Stating its criteria for decision making and giving reasons for decisions
	* Handling information properly and appropriately.
	* Keeping proper and appropriate records.
	* Taking responsibility for its actions.
4. **Acting fairly and proportionately**
	* Treating people impartially, with respect and courtesy.
	* Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
	* Dealing with people and issues objectively and consistently.
	* Ensuring that decisions and actions are proportionate, appropriate and fair.
5. **Putting things right**
	* Acknowledging mistakes and apologising where appropriate.
	* Putting mistakes right quickly and effectively.
	* Providing clear and timely information on how and when to appeal or complain.
	* Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.
6. **Seeking continuous improvement**
	* Reviewing policies and procedures regularly to ensure they are effective.
	* Asking for feedback and using it to improve services and performance.
	* Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.