Investigation of a complaint against the South Eastern Health & Social Care Trust

Report Reference: 202005285

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

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.

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

Case Reference: 202005285

Listed Authority: South Eastern Health & Social Care Trust (the Trust)

SUMMARY

This complaint was about how South Eastern Health & Social Care Trust (the Trust) managed an adult safeguarding referral made to them on 2 February 2023 by a care home involving two of its residents. One of the residents, resident A, is the complainant's mother.

My investigation found the Trust was not sufficiently rigorous in its assessment and it did not verify the adequacy of the Protection Plan put in place to safeguard residents at the care home. My investigation also found the Trust missed an opportunity to provide training and advice to the care home on making safeguarding referrals.

I concluded the Trust failed to manage the safeguarding referral in line with relevant standards. I therefore upheld the complaint. I was satisfied this failure would not have changed the initial screening assessment outcome, but it did call into question to the adequacy of the Protection Plan, as its contents were not verified.

I recommended the Trust apologise to the complainant for its handling of the referral, and I made further recommendations for service improvement and to prevent future recurrences.

THE COMPLAINT

1. This complaint was about how South Eastern Health & Social Care Trust (the Trust) managed an adult safeguarding referral made to it on 3 February 2023 by a care home involving two of its residents. One of the residents, resident A is the complainant's mother.

Background

2. At around 16.00 on 31 January 2023, care home staff found resident A sitting on her bed in her room. Staff saw another resident, resident X, standing in front of her with his trousers and pad pulled down. Staff reported the residents were not touching each other when discovered.

3. The care home completed an Adult at Risk of Harm Concern Form (APP1 Form) to report an incident. The reason for referral on the APP1 Form was *'sexual[1]'* and *'psychological harm or abuse[2]'*:
   - The care home manager completed Section 1 of the APP1 Form, which was dated 31 January 2023, although some of the information in Section 1 relates to events in the early hours of 1 February 2023; and
   - The care home's adult safeguarding champion (ASC) completed Section 2 of the APP1 Form, dated 2 February 2023.

4. The APP1 Form stated:
   - resident A *'has no complaints of any pain or discomfort and does not appear aware of any incidents happened'*; and
   - the care home *'contacted the out of hours GP and they contacted PSNI[3] who attended. Staff on duty when PSNI attended said the officers said they would not be taking forward due to resident's diagnosis of dementia but no official information regarding this'*.

5. On 3 February 2023 at 10.37, the Trust's Adult Protection Gateway Service (APGS) received the APP1 Form from the care home reporting the incident.

[1] See Appendix three of this report for NIASP Procedures' definition of sexual abuse
[2] See Appendix three of this report for NIASP Procedures' definition of psychological abuse
[3] Police Service of Northern Ireland

6. The care home stated on the APP1 Form this case would *'not normally meet the threshold for referral to Adult Safeguarding. No evidence of intent to harm, both residents have cognitive impairment.'* The care home also stated on the APP1 Form *'PSNI were contacted by out of hours GP and I would ask if Adult Safeguarding team would now screen given their involvement'*.

7. The Trust allocated a Designated Adult Protection Officer (DAPO) to screen the referral and determine whether it met the NIASP Procedures'[4] thresholds for serious harm[5] and referral to APGS[6].

8. The DAPO assessed the referral and the protection plan the care home had in place from the information on the APP1 Form and received during a telephone call with the care home manager. During this initial screening assessment, the DAPO did not speak with the other parties involved (the medical practitioners and the PSNI) or with the complainant (resident A's next of kin).

9. The DAPO screened out the referral at this initial assessment stage on the basis it did not meet the thresholds for serious harm or referral to APGS. The DAPO passed the case to the Trust's core team for the implementation of an alternative response comprising of:
    - The continued implementation of the care home's protection plan;
    - Resident A's key worker review of her needs and views; and
    - Resident X's keyworker to ensure the consideration of appropriate risk assessments.

10. The Trust communicated the assessment outcome and the alternative response to the care home and the complainant.

Issue of complaint

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

    Whether the Trust managed the adult safeguarding referral, received on 3 February 2023, in accordance with relevant policies and procedures.

[4] The Northern Ireland Safeguarding Partnerships' Adult Safeguarding Operational Procedures, September 2016
[5] See Appendix three of this report the definition of serious harm and flowchart.
[6] See Appendix three of this report for the factors in determining whether the threshold had been met.

INVESTIGATION METHODOLOGY

12. To investigate this complaint, I 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. To further assist with the investigation, I also obtained information and responses from the following third parties:
    - the care assistant who found the residents;
    - the out of hours GP service;
    - resident A's GP; and
    - the PSNI.

Independent Social Work Advice Sought

13. After further consideration of the issues, I obtained independent social work advice from an independent professional advisor with 35 years' experience working as a social worker with significant experience in adult safeguarding, services for older people and specific experience in investigating complaints involving care homes for older people and older people with a dementia diagnosis (ISWA).

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

14. I included the information and advice which informed the findings and conclusions 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

15. 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[7] of Good Administration.

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

16. 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 Northern Ireland Safeguarding Partnerships' Adult Safeguarding Operational Procedures, September 2016 (NIASP Procedures); and
    - The Northern Ireland Safeguarding Partnerships' Protocol for Joint Investigation of Adult Safeguarding Cases, August 2016 (Joint Protocol).

17. I outline the relevant sections of the guidance considered in my analysis and findings below.

18. In investigating a complaint of maladministration, my role is concerned primarily with an examination of the Trust's administrative actions. It is not my role to question the merits of a discretionary decision. That is unless my investigation identifies maladministration in the Trust's process of making that decision.

19. 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.

20. 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. I gave careful consideration to the comments I received before I finalised this report.

THE INVESTIGATION

Whether the Trust managed the adult safeguarding referral, received on 3 February 2023, in accordance with relevant policies and procedures.

Detail of Complaint

21. The complainant said the Trust mishandled its investigation of the allegations it received on 3 February 2023 of sexual and psychological harm or abuse on resident A by resident X. The complainant said the Trust *'failed to adhere to the NIASP Procedures'* with a *'systemic breach of the procedures'*.

22. The complainant said the Trust's investigation has *'been handled appallingly*. He stated his belief that the Trust refused to fully disclose *'what had happen [sic] in my [the complainant's] mother's bedroom*, noting that this had *'distressed him greatly'*. The complainant also said, he *'should be able to sleep contently in my bed knowing my mother is safe. I can't do that'*.

Evidence Considered

The Trust's response to the investigation enquiries

23. The Trust provided this Office with its response to the investigation enquires. It stated it did not find any failings in the way it had handled its investigation into the allegations reported to them. I outline details of this response in my analysis and findings below.

Third parties responses to investigation enquiries

24. In responses to the investigation enquiries, the third parties provided this Office with:
    - A witness statement from the care home staff who found the residents;
    - A copy extract of the GP Out of Hours Incident Report (Out of Hours Report);
    - A copy extract of resident A's GP's clinical notes; and
    - A report from the PSNI on the incident they attended at the care home.

25. I outline details of the responses and information from the third parties in my analysis and findings below.

Relevant Independent Professional Advice

26. I enclose the clinical advice received at Appendix two to this report. I outline my consideration of the advice in my analysis and finds below.

Analysis and Findings

Stage 1 Screening the Adult Protection Referral

27. NIASP Procedures Section 8.1 states *'a Designated Adult Protection Officer (DAPO) will be responsible for the management of each referral received by a HSC[8] Trust'.*

28. The Trust said on 3 February 2023 its APGS received the APP1 Form and allocated the Duty Social Worker to be the DAPO for the case.

29. NIASP Procedures Section 10 details the actions of the DAPO which include:
    - *'Ensure that a face to face contact with the adult in need of protection is completed without undue delay.'*
    - *'Determine whether the threshold for serious harm (Appendix4[9]) and the threshold for referral to the HSC Trust Adult Protection Gateway Service are met'.*
    - *'If referral does not meet the above protection thresholds, the DAPO will advise referrer and agree appropriate alternative safeguarding responses. At all times the least intrusive and most effective response should be made.'*

Face to face contact

30. Upon review of the Trust's records, I note the DAPO did not:

    - take any action to *'ensure a face to face contact* with *the adult in need of protection is completed without undue delay'* in line with NIASP Procedure; or

    - record a rationale for why this was not needed.

31. Having reviewed the NIASP Procedures, I consider the DAPO should have met resident A as soon as reasonably practicable upon assuming responsibility for the referral. If the DAPO felt it was not necessary in this situation to have met with resident A, I consider she should have recorded her rationale for this. In failing to do either of these, the DAPO failed to act in accordance with relevant standards. As a result, the only face to face contact resident A had following the incident was with the care home staff.

[8] Health and Social Care

[9] This is Appendix 5 (not Appendix 4) of NIASP Procedures & also detailed in the Appendix to this report.

32. This is of particular note as, the APP1 Form stated the out of hours GP did not attend the care home and the PSNI did not speak to resident A when it attended as she was asleep. This:
    - meant the DAPO did not corroborate the care home's comments through first hand evidence of resident A's wellbeing and awareness of the incident. She instead relied solely on the care home's account; and it
    - resulted in the DAPO having limited information on which to make an informed assessment.

Determining whether the thresholds have been met

33. NIASP Procedures Section 10 states part of the role of the DAPO is to *'clarify basic facts'.* I would consider this to involve liaison with the relevant professionals and significant others involved in the matter. In this case:
    (i) the care home
    (ii) the out of hours GP service and/or resident A's GP (medical practitioners); and
    (iii) the PSNI
    as the *'relevant professionals'*
    (iv) the complainant, as resident A's representative due to her dementia diagnosis.
    as the *'significant others'*
    I reviewed the DAPO's contact and liaison with each of these below.

(i) Trust's contact with care home

34. The Trust stated the DAPO phoned the care home manager the same day (3 February call) *'to gather further information'*.

35. The Trust's documentation does not record the DAPO's discussion during the 3 February call. In the Trust's response to this Office, it stated the DAPO:
    - *'gathered information pertaining to any previous history of adult safeguarding concerns'* by resident X;
    - confirmed resident X had *'no history of'* the actions displayed in this incident or of sexual assault;
    - clarified resident X *'had a history of wandering into other people's rooms and lying on the bed '* and there was *'no history of the person [resident X] removing his lower clothing or sexual assault'*; also *'sought clarity'* on resident A and resident B's capacity, both had a dementia diagnosis;
    - was informed resident A *'was not in distress'*; and

- gathered information on the *'involvement of the PSNI and GP'* in respect of the reported incident.

36. Having reviewed the Trust's records, I note the DAPO did not make a record of the 3 February call within the APP1 Form (or elsewhere) and the Trust has not supplied other documents to evidence that the DAPO queried, proactively sought or explored the following points:
    - The timeline following the incident to understand when:
        - the body map was undertaken. This information was not recorded on the map attached to the APP1 Form and the ISWA advised it *'should have [been] done'*. This meant the DAPO was not aware if the care home had completed it in a timely manner and resulted in the DAPO holding incomplete information.
        - the GP was called. The ISWA advised this was *'nine hours after the incident had occurred'.* However, because the DAPO did not establish this timeline, she was unaware of this delay, and any rationale for it. The DAPO missed the opportunity to discuss any potential safeguarding consequences with the care home connected to this delay in contacting the GP.
        - when the PSNI visited the care home. Although the PSNI attended promptly after receiving the GP's referral, the time of their arrival would have also highlighted the above delay in the care home contacting the GP.
    - The care home's categorisation of the incident as *'Sexual and Psychological Abuse'* on Section 1 of the APP 1 Form whilst also stating there was *'no evidence of intent to harm, both residents have cognitive impairment'* and the incident *'would not normally meet the threshold for referral'*.
        - The ISWA advised *'This was important because, without this information, the APGS would be unaware why Care Home staff believed that Sexual and / or Psychological Abuse may have taken place'.*
        - The ISWA further advised he did not believe *'it was appropriate for the incident to be categorised as Sexual and Psychological Abuse on the basis that Care Home staff did not know which other box to tick'.*

- What care home staff said to the out of hours GP.
  - The ISWA advised the DAPO *'did not establish'* what information the care home provided to the out of hours GP to result in them contacting the PSNI under the NIASP Procedures section 2.4 *'Where a criminal act is either alleged or suspected, a report must be made to the PSNI.'*
  - I note the ISWA advised based on the contents of the APP1 Form, it would not have been necessary for any party to involve the PSNI.
- Full details of the Protection Plan.
  - The ISWA advised the DAPO *'should have asked to see a written copy of the Protection Plan'* as the care home's references to a behavioural chart and fifteen minute checks *'do not provide enough information'.* This meant the DAPO did not have all the relevant information to make an informed decision on the Protection Plan's adequacy.
- The complainant's awareness of the incident and any concerns he raised with the care home.
  - This meant the DAPO did not know if the care home had provided the complainant with full details of the incident and the care home's actions to safeguard his mother. This resulted in the DAPO having incomplete information to inform subsequent communications with the complainant as resident A's *'significant other'* or to take account of any initial concerns that he may have had or raised with the care home.
- Coaching and training for the care home staff.
  - The ISWA advised the Trust *'should have liaised with the ASC about the Care Home Manager's and staff members' needs in relation to Adult Safeguarding training'* in view of the (i) uncertainty expressed by the care home manager in the categorisation; (ii) the need to report the incident; and (iii) the number of omissions in the completion of the APP1 Form.
  - Under the NIASP Procedures, where there is any doubt of the action the care home should take relating to an incident the care home should contact APGS *'for advice and guidance'*. I note the DAPO missed the opportunity to remind the care home of this service.

37. Having reviewed all relevant evidence, including the ISWA's advice, I find the DAPO failed to take sufficient steps to gather potentially relevant evidence and information from the care home to determine whether the referral met the thresholds in the NIASP Procedures. Furthermore, I find the DAPO failed to keep sufficient records when she failed to record her telephone conversation with the care home on 3 February. I will further address these failures later in this report.

(ii) Trust's Contact with Medical Practitioners

38. Following the 3 February call, the Trust stated the DAPO *'attempted'* but was *'unable to establish contact with the locum GP'* at the out of hours service to establish why the GP had contacted the PSNI.

39. The ISWA advised when the DAPO was unable to contact the out of hours GP, she should have contacted resident A's own GP who would *'have had access to the records of the Out of Hours GP's contact with the Care Home'* in the Out of Hours Report. In addition, I note the DAPO would also have had access to information supplied to resident A's GP, who followed up on the Out of Hours Report with the care home. The ISWA advised this meant the DAPO did not fully assess, or become aware of:

- the time of the care home call to the out of hours GP (01.00 on 1 February 2023) and why the care home had *'left it so long to contact the Out of Hours GP'* – some *'nine hours after the incident had occurred'*.
- the care home's call with the out of hours GP:
  - informing the GP *'a sexual assault had taken place, given that records indicate that they did not believe that this was the case'*; and
  - failure to make the out of hours GP aware *'both of the parties involved had Cognitive Impairments'.*

  I note these factors led the GP to contact the PSNI.
- why the out of hours GP was not aware of the full details of the situation in which the care home staff found the residents, resident A's *'presentation and emotional and physical wellbeing'*, and details of her completed body map.

- resident X having a *'history of exposing himself in the past'* which I note was included in the information available to resident A's GP. The ISWA advised this *'is of concern'* and that it *'changes how Care Home staff'* and the DAPO *'should have responded'* in respect of resident X's Protection Plan. The ISWA further advised the references to resident X's behavioural history meant *'there needed to be strategies in place to reduce the recurrence of these incidents'* included in the Protection Plan. He advised this was not undertaken.

40. The ISWA advised as a result, instead of establishing details of the care home's interaction with out of hours GP directly, the DAPO instead relied solely on the care home manager's account of that interaction.

41. The ISWA further advised the Trust's Initial Screening records *'do not contain justifications for why'* the DAPO *'did not contact the Resident's GP'.*

42. Having reviewed all relevant evidence, including the ISWA's advice, I find the DAPO failed to take sufficient steps to gather potentially relevant evidence and information from resident A's GP to determine whether the referral met the thresholds in the NIASP Procedures. I will further address this failure later in this report.

(iii) Trust's Contact with PSNI

43. Upon review of the Trust's responses to investigation enquiries, I note the DAPO was aware the PSNI visited the care home and of its decision not to investigate the incident further. Upon review of the Trust's records, I also note the DAPO did not contact the PSNI herself as part of handling this referral. I note the Trust's position that it was reasonable for the DAPO to rely on the information the care home provided regarding the PSNI's involvement, and it was therefore un-necessary for the DAPO to have contacted the PSNI directly during the initial screening or to complete a APJ1 form[10].

[10] Adult Joint Protocol Referral Form

44. However, the ISWA advised in taking this approach, the DAPO relied on *'second hand information'* from the care home in-relation to the actions of the PSNI and its rationale for not investigating the incident further. The ISWA further advised *'this was not appropriate'* and the Trust *'should have liaised directly with the PSNI during the Initial Screening process'.* Consequently *'the accuracy of the information'* in the APP1 Form regarding the PSNI's involvement was un-verified and therefore the Trust's decision not to consider it further was based on unsubstantiated information. The ISWA further advised, the DAPO missed another opportunity to discover directly the nature of the out of hours GP interaction with the PSNI, as well as details of the delayed timeline. I acknowledge the DAPO subsequently accepted she should have liaised directly with the PSNI at this stage in the process.

45. Having reviewed all relevant evidence, including the ISWA's advice, I find the DAPO failed to take sufficient steps to gather potentially relevant evidence and information from the PSNI to determine whether the referral met the thresholds in the NIASP Procedures. I will further address this failure later in this report.

(iv) The Trust's Contact with Next of Kin as resident A's representative

46. I reviewed the Trust's records and the chronology the Trust provided to this office. The chronology showed the DAPO did not contact the complainant during the initial screening assessment. Therefore the DAPO did not provide the complainant with an opportunity to put forward any concerns and/or additional or corroborating information for her to consider. This further limited the information on which the DAPO based her decision to screen out the referral.

47. The Trust, in its response to the draft report, commented *'The complainant was contacted by the Adult Protection Gateway Team duty team following receipt of the APP1 referral on the 3 February 2023. At this time the complainant confirmed they were aware of the referral and details of the incident. The complainant provided information as to what they would like to happen following the referral'.* However, the Trust records and chronology indicate this was part of the conversation that informed him of their screening decision, rather than consultation during the screening process to gather potentially relevant information.

Summary

48. I therefore consider the Trust failed to manage this referral in line with the NIASP Procedures. I accept the ISWA's advice that the DAPO should have been '*more rigorous*' in her handling of this referral.

49. In particular, the DAPO failed to ensure face to face contact with resident A without undue delay. Furthermore, the DAPO failed to take reasonable and appropriate steps to obtain all potentially relevant evidence and information from the care home, resident A's GP, the PSNI and resident A's next-of-kin, the complainant. As a result, the DAPO was not in possession of sufficient evidence and information to enable her to determine if this referral met the threshold for either significant harm or for a referral to APGS.

50. The First Principle of Good Administration, *'getting it right'* requires public bodies to act in accordance with relevant guidelines and to take proper account of established good practice. It also requires public bodies to make decisions which are reasonable, and '*based on all relevant considerations*'. I consider the Trust failed to adhere to this Principle due to the manner in which the DAPO handled this referral.

51. In addition, the Third Principle of Good Administration, *'being open and accountable'* requires public bodies to keep proper and appropriate records. I find the Trust failed to adhere to this Principal when the DAPO failed to keep a record of her telephone conversation with the care home on 3 February.

52. I consider these failures constitute maladministration that caused the complainant to sustain the injustice of uncertainty and frustration regarding the Trust's handling of this referral, as well as worry and upset about his mother's safety in the care home. I therefore uphold this element of the complaint.

53. However, despite finding maladministration in the Trust's administrative actions, I am satisfied that, after consideration of the ISWA's advice, the decision the DAPO ultimately reached was sound. I am satisfied, therefore, even if the maladministration had not occurred, the outcome to the referral would more than likely have been the same. Therefore, this finding of maladministration has not given me cause to question the outcome of the Trust's process in this case.

54. However, I accept the ISWA's advice that the Trust missed the opportunity to provide the care home with advice and support on the efficient and correct handling and referral of any similar incident in the future.

Protection Thresholds not met – Alternative safeguarding response

55. Section 10.4 of NIASP states *'Where it is determined that the threshold for Adult Protection has not been met, other alternative courses of action should be explored with the adult. At all times the least intrusive and most effective response should be made.'*

56. The APP1 Form states the Trust screened out the referral as the *'threshold [was] not met for adult protection response'* and it passed the case on *'as alternative response via core team'*.

57. The DAPO stated in Section 3 of the APP1 Form *'screening this back for alternative response and to ensure protection plan remains in place i.e. monitoring of resident [X] using behavioural chart*' and also stated *'A referral to a care manager/key worker for re-assessment and review of [resident A's] needs, views and care plan'*.

58. The Trust said the APGT contacted resident X's *'keyworker to ensure that appropriate risk assessments were considered'*. From my review of the Trust's documentation, the Trust did not record this interaction on the APP1 Form. I consider it should have done so. However, I am satisfied from the Trust's records, that this care review ultimately took place on 13 February 2023. As the review took place, I am satisfied the Trust adhered to relevant standards in this respect.

59. However, I refer to my finding above, that the DAPO failed to obtain sufficient evidence and information when she considered this referral, but ultimately her decision that the referral did not meet the threshold for significant harm was sound. I also refer to my consideration of the ISWA's advice that the DAPO did not obtain a copy of the Protection Plan or the Out of Hours Report/resident A's GP notes. He advised this meant the DAPO did not verify the adequacy of the Protection Plan and the Trust's reliance on the *'adequacy of the Protection Plan'* was therefore *'questionable'*.

60. The ISWA advised as a result, the Trust failed to ensure the Protection Plan considered or specified how any recurrence of resident X's *'behaviour will be responded to, in order to reduce the possibility'* of it and *'in order to protect other residents'*. I consider preventing such recurrence was a key element of the alternative action the Trust should have taken as part of its referral decision. I consider, therefore, the Trust should have obtained a copy of the Protection Plan and reviewed its adequacy as part of its handling of this referral.

61. The ISWA further advised it *'begs that question of whether there was anything more that could have been done to safeguard [resident A]'* due to the Trust's *'questionable'* reliance on the *'adequacy of the Protection Plan'*. Based on the ISWA's advice, I consider the Trust failed to adhere to the NIASP Procedures when it failed to ensure its alternative response was sufficient to prevent future recurrence of an incident of this type.

62. I therefore consider the Trust failed to adhere to the First Principle of Good Administration, set out above. It also failed to adhere to the Third Principle, as set out above, in-relation to its record-keeping at this stage in the referral process. These failures constitute maladministration that caused the complainant to sustain the injustice of uncertainty, upset and worry regarding his mother's safety in the nursing home. I therefore uphold this element of the complaint.

Communication and recording of screening decision

63. Section 10 of NIASP Procedures states the action of the DAPO is to *'Complete the relevant documentation advising the referrer of outcomes of the screening decision. The referrer, if appropriate, notifies service user / family with due regard to maintaining the safety of the service user in need of protection.'*

64. The records show the Trust informed the care home manager about the decision to close the referral with an alternative response. This is in accordance with the NIASP Procedures. I also note the Trust contacted the complainant directly to explain the outcome. I commend the Trust for going beyond the NIASP Procedure by having this telephone conversation with the complainant, as resident A's next of kin, rather than the care home (as referrer) informing him of the decision in line with the NIASP Procedures.

65. I note the Trust completed Section 3 of the APP1 Form to provide a record of APGS's initial screening, the *'details of decision making',* any need to inform to the PSNI and RQIA and the actions taken following the screening decision of the referral. It also recorded in this section the DAPO's call with the complainant.

66. Regarding this communication, I note the Trust informed the complainant on that call:
    - that *'the PSNI would not be investigating'*
    - that *'no investigation would take place by the Adult Protection Gateway Team and the Community Team would be tasked to follow up and review as an alternative response'.*
    - of the *'rationale of the assessment'* and its outcome.

67. Upon review of the Trust's record of the call with the complainant, I note the complainant queried several elements of the Trust's decision and its process. He continued to express concern for his mother's safety and wellbeing. It is clear from this complaint, the complainant still has questions he considers to be unanswered, despite having this call with the DAPO. I refer to my finding above that the DAPO should have taken steps to discuss the incident with the complainant, as resident A's next of kin, prior to making her decision. If the DAPO had done so, this may have improved the communication between the Trust and the complainant at this latter stage in the process. The complainant said he still does not know from the Trust exactly what happened that day. Having reviewed the Trust's documentation, there is no record of the Trust providing a full rationale for its decision on the telephone call, or afterwards.

68. I consider this to be a failure in the Trust's communication with the complainant which constitutes maladministration. The Second Principle of Good Administration requires public bodies to be *'customer focused'*. The Third Principle requires them to be *'open and accountable'*. I consider the Trust failed to adhere to these Principles in this respect. These failures caused the complainant to sustain the injustice of uncertainty and frustration regarding the Trust's process and upset and worry about his mother's safety. I therefore uphold this element of the complaint.

69. Regarding record-keeping, I reviewed the APP1 Form and noted the following:
    - the Trust stated the DAPO had a telephone call with the PSNI following her conversation with the complainant. However, I note the DAPO did not record this on the APP1 Form, or elsewhere in the records.
    - in section 3 of the APP1 Form, the DAPO did not complete the name of the RQIA inspector. This was a requirement on the form.
    - also in section 3 of the APP1 Form, the DAPO stated '*Referral for internal quality improvement action'*. However, I note there are no details on the APP1 Form, or elsewhere in the records, outlining what this entailed or if it was undertaken.
    - I consider the DAPO should have undertaken all three aspects of record keeping identified.

70. As established earlier in this report, the DAPO failed to obtain sufficient evidence and information from relevant parties when she handled this referral. I also note the DAPO did not record any rationale for not contacting a number of the parties at all on the APP1 form. If the DAPO decided she did not need to contact any of those parties, she should have recorded the rationale for her decision on the APP1 Form. When considered together with the above record-keeping concerns, I find the DAPO failed to keep sufficiently thorough and detailed records of her management of the referral and the next steps for the referral following her decision. The Third Principle of Good Administration, *'being open and accountable'* requires public bodies to keep proper and appropriate records to support decision-making and administrative actions. I find the Trust failed to adhere to this Principle. This failure constitutes maladministration that caused the complainant to sustain the injustice of uncertainty regarding the DAPO's decision-making, and the next steps the Trust were to take to safeguard his mother. I therefore uphold this element of the complaint.

Observation

71. I note under NIASP Procedures Section 10, the DAPO should *'Complete the relevant electronic information system'.* However, the Procedures do not outline what details the DAPO should record on that system. I consider this section of NIASP Procedures could be strengthened to include that the DAPO should ensure they enter a clear record of the screening process and rationale for the decisions made on the relevant electronic record system. This would bring the actions in line with the Third Principle.

72. Whilst I appreciate the NIASP Procedure is a regional procedure, I would strongly encourage the Trust to put forward my observation to the Northern Ireland Adult Safeguarding Partnership to strengthen Section 10 to help avoid future occurrences of poor record keeping.

CONCLUSION

73. I received a complaint about the Trust's management of an adult safeguarding referral. I upheld the complaint for the reasons outlined in this report. I consider this constitutes maladministration.

74. In addition, the Trust missed opportunities for service improvement to provide training and advice to the care home:
    - in order to prevent a similar incident occurring in the future with the Protection Plan; and
    - on the efficient and correct handling and referral of similar incidents in the future.

75. I recognise the failure caused the complainant to sustain the injustice of uncertainty, frustration, worry and upset regarding the Trust's management of the referral and his mother's future safety. I consider he lost trust in the Trust's ability to help safeguard her.

Recommendations

76. 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).
    - Full, and appropriately redacted, details of the incident, the protections put in place and the review of the Protection Plan.

77. I recommend the Trust reviews the Protection Plan to ensure its suitability, taking account of the ISWA's advice.

78. I further recommend for service improvement and to prevent future recurrence the Trust:

- carries out a random sampling audit of adult safeguarding referrals to the APGS (in the 12 months prior to the issuing of the final report) where the referral was screened out with an alternative response, to ensure an adequate assessment had taken place; the Protection Plans were appropriate and where appropriate carers/family members have been provided with full information on the incidents referred/assessed.
- Bring this report to the attention of the relevant staff so the learning identified can be reflected upon;
- provide appropriate training to the DAPOs and their line managers on assessment, record keeping, and how to provide support to care homes in addressing referrals of this nature.

79. I recommend the Trust implements an action plan to incorporate these recommendations and should provide me with an update within six months of the date of my final report. The Trust should support its action plan with evidence to confirm it took appropriate action (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff read and understood any related policies).

MARGARET KELLY
Ombudsman

March 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.