



Northern Ireland

Public Services

Ombudsman

Investigation of a complaint against Western Health and Social Care Trust

Report reference: 202400652

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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.

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Appendix 1 – The Principles of Good Administration

Case Reference: **202400652**

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

SUMMARY

I received a complaint about care and treatment the Western Health & Social Care Trust (the Trust) provided to the complainant's daughter (the patient) between 2020 and 2024 through its Child and Adolescent Mental Health Service (CAMHS) and Family Intervention Service (FIS).

The complainant said the Trust would not assess the patient for Pathological Demand Avoidance (PDA) associated with autism, despite her repeatedly advising CAMHS and FIS staff of her concerns. The complainant said she was frustrated when the Trust assessed the cause of the patient's behavioural problems to stem from difficult family relationships, and she paid for a private assessment which identified PDA traits in the patient.

The investigation identified the Trust appropriately considered the patient's behaviour in accordance with guidance when it concluded she did not display the signs of autism required to refer her to its Children and Young People's Autism Service. It also established PDA is not a formally recognised condition and so it was appropriate the Trust did not have a specific PDA assessment referral pathway in place.

The complainant also said the Trust refused to help her when she telephoned a CAMHS nurse seeking immediate assistance with the patient's violent outburst. The investigation established it is not within CAMHS' operational remit to deal with emergency situations and its staff provided the complainant with the appropriate advice of telephoning the Police in such circumstances.

The complainant also said the Trust's social workers failed to conduct the appropriate number of house visits with her and the patient. The investigation found the social worker failed to adhere to guidance to set a timeframe to her support plans. In addition, the social worker failed to conduct home visits in accordance with the Trust's policy, which directed a home visit every four to six weeks. In not doing so, the Trust caused the complainant the upset and frustration of witnessing inadequate care and treatment for the patient and uncertainty around the provision of that care.

I therefore partially upheld the complaint.

I recommended that the Trust provide the complainant with a written apology for the injustice caused as a result of the failure identified. I also made recommendations for service improvements to prevent recurrence of this failure.

THE COMPLAINT

1. This complaint was about care and treatment the Western Health & Social Care Trust (the Trust) provided the patient through its Child and Adolescent Mental Health Services ¹(CAMHS) and Family Intervention Service (FIS²) between 2020 and 2024. The complainant is the patient's mother.

Background

2. On 14 February 2020, a General Practitioner (GP) referred the patient, then aged nine years, to CAMHS due to a history of low mood, anxiety and escalation in behaviours. This was the first of several referrals which saw CAMHS accept and then discharge the patient.
3. The complainant believed the patient had Autism Spectrum Disorder (ASD³) and displayed symptoms of Pathological Demand Avoidance (PDA⁴). CAMHS assessed the cause of the patient's behaviours as stemming from family relationship issues and requested social work involvement from FIS.

Issue of complaint

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

Whether the Trust provided the appropriate care and treatment to the patient between 14 February 2020 and 14 August 2024

Specifically, this will consider:

- Consideration to assess the patient for ASD and PDA;
- CAMHS response to concerns the complainant raised via telephone call; and
- Frequency of home visits by FIS social workers.

¹ A National Health Service (NHS) service providing support and treatment for young people up to the age of 18 who are experiencing mental health difficulties.

² A Trust service ensuring the provision of social work provision to children and families.

³ A complex developmental condition affecting how people interact with the world, especially in social communication and interaction, and repetitive behaviours.

⁴ A profile of autism whereby individuals share autistic characteristics currently defined as persistent difficulties with social communication and social interaction, and restricted and repetitive patterns of behaviour, activities or interests.

INVESTIGATION METHODOLOGY

5. 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

6. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisors (IPAs):
 - A Registered Mental Health Nurse (RNMH) with nine years' experience of working with children and young persons with mental health problems, holding the qualifications DipHe and BSc(Hons). He is also a specialist in safeguarding children. (MHN IPA);
 - A qualified Social Worker with 36 years' experience, holding the qualifications BA (Hons) in Psychology and a Certificate in Social Work Diploma in Applied Social Studies. Much of his experience is associated with mental health services. (SW IPA); and
 - A Consultant Child and Adolescent Psychiatrist with 17 years' experience, working in Child and Adolescent Mental health Services (CAMHS), holding the qualifications MSc, MRCP, FRCPsych, and MD. (P IPA).

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

7. The information and advice which informed the findings and conclusions are included within the body of this report. The IPAs 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

8. 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 Principles⁵:

- The Principles of Good Administration.

9. 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:

- Health and Social Care Trusts (HSCT) Working Together: A Pathway for Children and Young People through CAMHS, March 2018 (HSCT guidance on CAMHS);
- Health and Social Care Trusts (HSCT) Referral Guidelines for Child and Adolescent Mental Health Services (CAMHS), 1 July 2012, (HSCT CAMHS referral guidelines);
- Western Health and Social Care Trust (WHSCCT) Referral Pathway for Diagnostic Assessment, undated, (Trust's Referral Pathway for Diagnostic Assessment)
- National Institute for Health and Care Excellence (NICE) Clinical Guideline 128 on Autism Spectrum Disorder in under 19s: recognition, referral and diagnosis, 20 December 2017 (NICE CG128)
- National Institute for Health and Care Excellence (NICE) Clinical Knowledge Summaries (CKS) on When Should I Suspect Autism in a Primary School Child, April 2022, (NICE CKS on autism in a primary school child);
- Northern Ireland Social Care Council (NISCC) Standards of Conduct and Practice for Social Workers, August 2019, (NISCC Standards);
- Nursing and Midwifery Council (NMC) Code, 31 March 2021, (NMC Code);
- British Association of Social Workers (BASW) Code of Ethics, July 2021, (BASW Code of Ethics); and
- UNOCINI (Understanding the Needs of Children in Northern Ireland) Guidance, June 2011, (UNOCINI Guidance).

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

⁵ These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

10. 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.
11. 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 in preparing this final investigation report.

THE INVESTIGATION

- **Whether the Trust provided the appropriate care and treatment to the patient between 14 February 2020 and 14 August 2024.**

Relevant Trust records

12. I reviewed relevant Trust records pertaining to patient's involvement with CAMHS and FIS during the complaint investigation period. These included referrals, assessments and records of contact and home visits.

Relevant Independent Professional Advice

13. MNH IPA, SW IPA and P IPA advice appears at Appendix Two. I have set out my consideration of that advice in the analysis and findings section of this report.

Consideration to assess the patient for ASD and PDA

Detail of Complaint

14. The complainant said:
 - The patient displayed "*very challenging behaviour*" from birth which she believed was a manifestation of "*ASD with a PDA profile*";
 - She wanted the Trust to assess the patient for ASD, but it declined to do so as it said she had "*no autism traits*";
 - On two occasions when she told social workers of her concerns the patient had PDA, one social worker said "*I've never heard of that*", whilst another asked what it was.
 - She felt so much "*frustration*" at the Trust "*not listening*" to her she paid for a private psychologist to assess the patient in April 2023, who "*diagnosed [the patient] with ASD and PDA*".

- The Trust repeatedly failed to “*listen*” to her which has been “*demoralising*” for her.

Trust’s response to investigation enquiries

15. The Trust stated:

- “*Indicators that [the patient] was presenting with ASD/PDA traits were not apparent to CAMHS*”;
- “*There was no indication from school that [the patient] was presenting with ASD/PDA traits within the school setting*”;
- “*It was felt that a range of family relational issues and emotional issues were underlying [the patient’s] presenting issues*”;
- Social workers at the FIS are “*not*” mental health trained and therefore rely on the “*expertise*” of the professionals in CAMHS.
- “*There is no pathway to make a referral specifically for PDA as PDA is not currently a formally recognised diagnosis*”.
- Its ASD service has “*not accepted*” the patient’s private assessment diagnosis and she remains on its assessment waiting list.

Analysis and Findings.

CAMHS

16. Records document the patient’s first involvement with the Trust for behavioural issues followed a GP referral to CAMHS on 14 February 2020. In that referral, the GP described the patient would “*shout*” and “*physically lash out*” at the complainant. HSCT CAMHS referral guidelines describes it as a service intended to “*support*” children and young people who have “*emotional, behaviour and mental health difficulties*”, as well as in cases where there is a “*likelihood*” the child or young person has a “*diagnosable*” mental health disorder.
17. Records reflect the GP made a total of five referrals to CAMHS for the patient during the investigation timeline and they resulted in four periods of assessment and supportive treatment. In March 2021, CAMHS assigned social work provision for the patient and the complainant. I include details of the timings of acceptance to, and discharge from, CAHMS within Appendix Four. The patient’s GP made the fifth referral to CAMHS on 3 November 2023.

18. Records show CAMHS clinicians did not diagnose the patient with any recognised mental health disorder but instead assessed her challenging behaviours as stemming from a “*difficult*” family relationship. The P IPA advised it is a “*very well recognised*” phenomenon in psychiatry that children can have “*relationship difficulties*” with parents. He further advised the patient’s difficulties “*seemed*” more related to problems in her relationship with her mother than ASD manifestation. He also advised the available information “*did not suggest*” the difficulties were “*primarily*” a problem with the patient’s neurodevelopment⁶ such as “*autism*”.
19. I note the CAMHS diagnosis frustrated the complainant, who believed the Trust should have assessed the patient for PDA associated with ASD. Records document the complainant voiced her concerns to CAMHS clinicians on multiple occasions the patient displayed signs of PDA. I am therefore satisfied CAMHS staff were aware of the complainant’s beliefs in that regard.
20. The P IPA advised PDA is a “*controversial*” term as some clinicians “*believe*” it exists as a condition “*independent*” of ASD, whilst others do “*not currently agree*” it is a “*distinct diagnosis*” at all. The P IPA advised there is “*no*” NICE guidance on the “*assessment, diagnosis or treatment of PDA*” and advised he was “*not aware of any NHS Trust with a specific referral for pathway for PDA*”.
21. The Trust’s Referral Pathway for Diagnostic Assessment specifies “*only*” health professionals or an educational psychology service⁷ can refer children⁸ to its Children and Young People’s Autism Service⁹ for an autism assessment. I am therefore satisfied it was within the remit of CAMHS to make that referral if it considered it appropriate. The Trust’s Referral Pathway for Diagnostic Assessment references NICE CG128 when it requires referrals to include examples of difficulties across different social environments, such as in the “*school*” setting. I could find no evidence contained within records the patient displayed challenging behaviours at school. To the contrary, in records dated 30 September 2020, a mental health practitioner noted they had “*no concerns*” about the patient’s behaviour at school. The P IPA advised CAMHS clinicians did not see “*sufficient evidence*” of autism to warrant a referral to the Trust’s Autism Service “*at that time*”. Having reviewed the relevant records and applicable guidance, I accept that advice.

⁶ The way in which the brain builds and organizes itself, and how it works in everyday life.

⁷ A team of psychologists employed by the education authority trained in child development.

⁸ Aged from three years of age and up to 17 years nine months

⁹ A team responsible for diagnosing autism.

22. The complainant said the sense of *“frustration”* she experienced by the Trust not assessing the patient for ASD with PDA led her to task a private psychologist to assess the patient in April 2023. The complainant told my office that psychologist diagnosed the patient with ASD and PDA. The multi-disciplinary diagnostic assessment report concluded the patient’s presentation was *“consistent”* with an ASD diagnosis, but the P IPA advised it did not refer specifically to the patient having a *“diagnosis”* of PDA. He advised the report concluded the patient had *“the behavioural profile associated with PDA”* and further advised the report *“avoided”* the term *“diagnosis”* in relation to PDA as *“there are currently no internationally agreed criteria for diagnosis of PDA”*. I accept that advice.
23. The P IPA advised CAMHS acted appropriately by *“not”* referring the patient for ASD and PDA assessment. I accept that advice. Although it was aware of the complainant’s belief the patient had ASD and a private Spectrum Multi-disciplinary Diagnostic Team subsequently diagnosed her with ASD, I am satisfied none of the information CAMHS had about the patient’s behaviours prior to November 2023 indicated a requirement for an assessment referral. I also find that given PDA is not currently formally recognised, either as part of an ASD profile, or as a medical diagnosis in its own right, it was not unreasonable that the Trust did not pursue it as a potential diagnosis for the patient. Records show the patient’s GP subsequently referred her to the Trust’s Children and Young Persons Autism Service and I note she is currently on its waiting list for assessment of autism. Having considered the P IPA’s advice, I am satisfied the Trust referred the patient for this assessment once she met the requirements for it to do so. I therefore do not uphold this element of the complaint.

Social Workers

24. The complainant said she felt *“frustrated”* when she told social workers her belief the patient had PDA, and their responses indicated they did not know what PDA was. The SW IPA advised he *“agreed”* with the Trust’s response that social workers are not trained in mental health. He further advised the response of a social worker in circumstances where someone raised the suggestion a patient had an undiagnosed mental condition depended on *“context”*. In the case of the patient, she was *“under the care of CAMHS”* staff who assessed her and concluded she was not displaying

autism traits. Point 9 of the Standards for Social Workers requires social workers to “*make and receive referrals appropriately*”. The SW IPA advised it would not have been appropriate for the social workers to make referrals to the Trust about the complainant’s disclosure, as the Trust was already aware of those concerns. Having reviewed the records and the relevant guidance, I accept that advice. I also refer to my finding above that PDA is not currently recognised as a medical condition, or part of the ASD profile. I am satisfied it was not unreasonable that the social worker did not have a knowledge or understanding of PDA. I therefore do not uphold this element of the complaint.

Observation

25. The P IPA observed the Trust “*should*” have considered offering the patient an assessment by a Child and Adolescent Psychiatrist, particularly in November 2023 by which time the patient had had “*a long history*” of challenging behaviours that had not responded to psychosocial interventions. That assessment is “*different*” from the autism assessment the complainant wanted, but the P IPA commented the patient “*might*” have benefitted from a psychiatric assessment to explore for an anxiety and/or mood disorder. Whilst it is separate from the issue the complainant brought to my Office, I strongly advise the Trust to give serious consideration to offering the patient an assessment of this type upon receipt of my final investigation report, in line with the P IPA’s observation.

CAMHS response to concerns the complainant raised via telephone call

Detail of Complaint

26. The complainant said:

- On an occasion after CAMHS discharged the patient the first time, she rang its staff as she needed “*help*”.
- The patient “*was physically lashing out*” at her, damaged the house, and “*wanting to cut herself*” with a knife.
- The staff member told the complainant to “*ring Police*” as they could not assist as the patient was “*not at CAMHS anymore*”.
- CAMHS was the organisation “*that were meant to help us but didn’t*”.

Trust’s response to investigation enquiries

27. The Trust stated:

- CAMHS administrative and clinical team are “*extremely cognisant*” of the impact emotional and psychological distress may have on the young person and family.
- Responding to highly emotive telephone calls requires a combination of “*active listening, empathy, and de-escalation techniques*”.
- The CAMHS service is not set up to deal with emergency situations of that type. It therefore provides “*advice*” to parents to contact PSNI¹⁰ “*for assistance*” if a young person is presenting a “*significant and imminent*” risk to self or others.

Analysis and Findings.

28. Records document CAMHS discharged the patient from its service provision for the first time on 26 August 2021. They document the complainant rang CAMHS and spoke with a mental health nurse at 10:32 on 2 November 2021. That telephone call lasted 35 minutes. The complainant was unable to recall the specific date of the call she described. However, having reviewed the patient’s records, on the balance of probabilities, I consider that telephone call to be the one the complainant referred to in her complaint. Records document the complainant told CAMHS staff she was generally “*unhappy*” with the service CAMHS previously delivered, and voiced concerns about the patient’s ongoing “*behaviours*” which included “*meltdowns*”, “*physical attacks*” on the complainant, and writing notes to say she would be “*better off dead*”. Nothing recorded in notes reflect the complainant telephoned CAMHS in response to the patient experiencing an episode of violent behaviours which was then on-going.
29. The MHN IPA advised there were “*significant*” differences between the content of the telephone call the complainant described in her written complaint to the Trust, and within the records CAMHS retained. I cannot account for the discrepancies and have no additional independent evidence on which to base my findings. The NMC Code requires nurses to complete all records “*accurately*”. In the absence of corroborating evidence or information, I have no reason to consider the records are not accurate.
30. Although records do not reflect the complainant asked for immediate help in response to the patient’s behaviour, and nor do they reflect the CAMHS nurse told

¹⁰ Police Service of Northern Ireland.

the complainant to contact Police, the MHN IPA advised that would have been the “*appropriate*” response in those circumstances. The MHN IPA advised there was “*nothing*” CAMHS could have done to support the complainant and the patient, and “*only*” the Police could have “*safely*” intervened. I accept that advice. The records do not document the nurse referenced the patient’s status with CAMHS as rationale for refusing the offer of any assistance. The MHN IPA advised the records evidence CAMHS staff “*listened to*” and “*adequately considered*” the complainant’s concerns, and gave appropriate advice, in accordance with the NMC Code’s requirements. I therefore do not uphold this element of the complaint.

Observation

31. The MHN IPA advised whilst no guidance specifically addresses this scenario, the NMC Code requires nurses to communicate “*clearly*” with patients and service users. He further advised it would have been “*helpful*” in this case if the CAMHS nurse explained to the complainant why it was “*not best placed*” to help the patient at that time. I could find nothing recorded to show the nurse made that explanation. I therefore encourage the Trust to reflect on the MHN IPA’s advice in its practice going forward.

Frequency of home visits by social workers

Detail of Complaint

32. The complainant said:

- When the Trust assigned the second social worker to the family “*there wasn’t much [she] was doing.*”
- There were occasions she waited on the social worker calling to the house and she “*never*” turned up.
- She “*can’t remember*” the last time the social worker did a home visit.

Trust’s response to investigation enquiries

33. The Trust stated:

- It acknowledged there were times the social worker had to cancel or reschedule visits due to “*crisis situations*”. It “*sincerely apologises*” for that.
- It is “*best practice*” that social workers visit family support cases on “*at least*” a four to six weekly basis. If there are “*presenting issues*”, social workers “*should*” visit more often as “*determined via social work assessment*”.

Analysis and Findings.

34. Records document the patient's social worker made an introductory visit to the complainant and patient on 10 February 2022, when she provided an "overview" of the family intervention service. This was in accordance with Section 1.7 of the NISCC Standards which requires a social worker to "explain" their role and the "purpose" of their involvement to a service user.
35. The records note the social worker's intention to "arrange" case planning, which she then held with the complainant and the patient on 8 March 2022. The social worker produced a "Family Support Initial Plan" which logged her goals in supporting the family. Although the form allowed her to complete a "target date" against each planned action and desired outcome, records show she left those sections blank. The social worker also did not record her intended frequency of visiting with the patient. Section 4.8.4, paragraph five of UNOCINI Guidance requires social work practitioners to "attach" relevant timeframes to their family support plans. The SW IPA advised the frequency of home visits "should have been documented". He further advised there was specific work the social worker needed to complete with the family and so she "should" have agreed the "pattern of visits" with the complainant and the patient. He also advised an agreement as to the frequency of visits would let the complainant know if they were "being done on schedule". Having reviewed the relevant records and guidance, I accept this advice. I consider this constitutes a failure in the service and support it provided to the complainant and the patient.
36. In its response to my office, the Trust stated it was "best practice" for social workers to visit the family "every four to six weeks". Records show the social worker did not achieve the target frequency of visits in March 2022, April 2022, October 2022, November 2022, January 2023, February 2023, April 2023, May 2023, June 2023, July 2023 or August 2023. I consider the Trust's failure to adhere to its accepted practice in this respect constitutes a further failure in the service and support it provided to the complainant and the patient.
37. Records document two occasions on which the social worker cancelled a scheduled home visit with the complainant. On those occasions, she notified the complainant with advance notice on the day of the visit, claiming she was "dealing with an emergency", and a colleague was "sick". On the third occasion she provided a belated apology and claimed she "hadn't" put the visit date in her diary. Paragraph

2.7 of the NISCC Standards requires social workers to “*honour*” their work commitments, agreements and arrangements and to “*explain*” to service users when that is not possible. I am satisfied the social worker had good reason to cancel the visits on the first two occasions and she discharged her requirement appropriately by contacting the complainant with an explanation. It is unfortunate the social worker did not properly record her scheduled appointments on one occasion, and I do not doubt the frustration it caused the complainant. I find this was a failure in service and support on that occasion. However, I am satisfied one error is not indicative of a pattern of such behaviour for the social worker.

38. Records document six occasions during the investigation period on which the complainant cancelled a social work home visit, as opposed to the social worker. I found nothing within records to show the social worker considered rearranging those visits. The SW IPA advised even if the Trust aspired to meet its own target frequency of conducting a home visit every four to six weeks, then a cancelled visit might mean “*the family was not visited for anything between eight and 12 weeks*”. The SW IPA advised this was “*not adequate*” and an infrequency of visits “*could have resulted in drift in terms of work she was doing with the mother and the child*”. I accept that advice. I find the Trust’s failure to conduct the appropriate frequency of home visits adversely impacted on the effectiveness of the service it provided to the patient. This also caused the complainant to experience frustration, uncertainty, distress and anxiety relating to her daughter’s service and support. I therefore uphold this element of the complaint.

CONCLUSION

39. I received a complaint about the care and treatment provided to the patient by the Trust between 2020 and 2024.
40. Based on my consideration of all the evidence available, I partly uphold the complaint. The investigation established the Trust failed to ensure its social worker visited with the complainant and the patient at an appropriate frequency, in line with its own established practice.
41. However, the investigation also established the Trust acted appropriately when CAHMS concluded the patient did not require an ASD assessment at that time. It

established the Trust acted appropriately in the way a CAMHS nurse dealt with the complainant's concerns during a telephone call.

42. I am satisfied the failure identified caused the complainant frustration, uncertainty, and distress at experiencing inadequate service and support

Recommendations

43. 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 failure identified (within one month of the date of this report).
44. I further recommend for service improvement and to prevent future recurrence, the Trust:
- a. Shares this report with staff involved in the patient's care and asks them to reflect on the failure identified.
 - b. Addresses the failure with the patient's social worker and introduces a mechanism at her next performance appraisal to monitor her future actions in similar circumstances.
 - c. Provides training to relevant staff reiterating the importance of adhering to UNOCINI Guidance in attaching timelines to their support plans.
45. I recommend the Trust implements an action plan to incorporate these recommendations and should provide me with an update within **three** 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
NI Public Services Ombudsman

October 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.