Report of the reasons for discontinuing an investigation into a complaint against the Northern Health & Social Care Trust

NIPSO Reference: 17714

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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. She may also investigate and report 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.

Where the Ombudsman finds maladministration or questions the merits of a decision taken in consequence of the exercise of professional judgment she must also consider whether this has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. The Ombudsman may recommend a remedy where she finds injustice as a consequence of the failings identified in her report.

The Ombudsman has discretion to determine the procedure for investigating a complaint to her Office. Section 43 of the 2016 Act provides for the Ombudsman to report on a case where the investigation is being discontinued.

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.

THE COMPLAINT

1. A member of the public complained about the Northern Health and Social Care Trust's (the Trust) handling of events following care provided by Homecare Independent Living (HCIL) to her mother (the resident) in February 2015. The complainant's mother sustained two episodes of 'falls', on 22 and 24 February 2015, while being raised in a stand-aid device during care assistant visits to provide personal care. She was admitted to hospital on 25 February 2015 and died just over a week later from a heart condition.

2. These fall episodes were reported to the Trust by the complainant. The Trust engaged in a Serious Adverse Incident (SAI) process to investigate events. The SAI investigation which was initiated at Level 1 as a Serious Event Audit to establish what had happened and learn lessons, began after family notification of the falls and initially did not adequately engage with the family. After prolonged representations from the family to the Trust and its Chief Executive an additional Level 2 investigation (Root Cause Analysis – a methodology of establishing causes of events) began with a degree of independent lay person involvement. This investigation engaged with the family and HCIL over a protracted period of time but failed to engender any confidence and trust within the family that their concerns were being appropriately investigated. The final outcome of the SAI process was completed by submission of a Report to the Health and Social Care Board (HSCB) in March 2017. The Trust acted under the version of the SAI process in operation at the time (October 2013 Version 1). The HSCB had forwarded Guidance[1] to all Trusts on Engagement/Communication with the Service User/Family/Carers following a SAI in January 2015. At around the same time the Donaldson Report[2] also identified service user/family communication failings in the operation of the SAI process. The HSCB has issued a revised

[1] Engagement/Communication with Service User/Family: http://www.hscbusiness.hscni.net/pdf/23-02-2015_Guidance_on_communication_following_a_Serious_Adverse_Incident1.pdf (January 2015)
[2] Report of Sir Liam Donaldson into Health and Social Care Governance arrangements in NI: https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/donaldsonreport270115_0.pdf (December 2014)

SAI process in November 2016 (Version 1.1) that includes an addendum, which specifically addresses issues of user/family engagement.

3. SAI is a systematic measure for health and social care bodies to investigate serious incidents, to safeguard patients and to provide learning for the wider health service. The investigation must be conducted promptly, with an emphasis on learning and with no attribution of blame. This includes responsibility to learn from an incident and to minimise the risk of recurrence. The model seeks to provide a consistent approach to[3]:

   - what constitutes a serious adverse incident;

   - clarifying the roles, responsibilities and processes relating to the reporting, reviewing, dissemination and implementation of learning;

   - fulfilling statutory and regulatory requirements;

   - tools and resources that support good practice.

4. The Trust Chief Executive of the Trust wrote to me on 15 March 2017 indicating that following the SAI investigation they were unable to resolve the outstanding questions and criticisms posed by the complainant within the SAI process. The Trust requested that I consider matters under the power contained in Section 6 of the 2016 Act where the listed authority has been "unable to resolve the complaint". I welcome the Trust adopting such a position in this case.

5. In the event the complainant herself brought the case to my Office, so I was able to accept the case for investigation. She also complained against Homecare Independent Living, and a separate investigation is continuing into that matter.

6. After obtaining relevant documentation, I considered that substantial acknowledgement of the failings in this case were forthcoming from the Trust.

[3] Current SAI Guidance (2016) http://www.hscboard.hscni.net/download/PUBLICATIONS/policies-protocols-and-guidelines/Procedure-for-the-reporting-and-follow-up-of-SAIs-2016.pdf

7. I have taken account of the crucial role of the SAI process in ensuring quality care in health service governance. The importance of an SAI process feeding into quality and safety improvement is fully rehearsed in the Donaldson Report from 2014. The Department of Health, HSCB and Trusts have considered the outcomes of that Report and changes have been made, particularly focused on hearing the 'voice' of the family involved. The extent of the issues with SAI and patient safety are also fully examined in the recent report by Mr Justice O'Hara in The Inquiry into Hyponatremia related deaths[4]. While HSC policy and guidance have been amended to reflect experience and practice since the first introduction of regional adverse incident management 15 years ago, the initiation, investigation and reporting of such SAI matters remain problematic. This is a recurring issue of concern in complaints made to my Office.

8. I have carefully considered all the available evidence in this matter to include: the documents obtained from the Trust and the complainant, the attitude adopted by the Trust in apologising, acknowledging failings and seeking to refer the matter to me, and the Trust's agreement to an action plan arising from this complaint. I have also considered balancing the necessity of openness and accountability which underpin good administration, with adopting a proportionate response in my investigation and seeking an appropriate solution with potential benefit to the general public.

The Trust's Response

9. The Trust has agreed to the following in relation to the complaint:

   The Trust recognise that communicating effectively with the family of [the deceased] was a vital part of the SAI process. The family should have received timely information of actions that the Trust were undertaking and should have been fully informed of the processes followed to investigate the incident.

[4] http://www.ihrdni.org/Vol3-08-Current.pdf

The Trust should also have made clear at the outset that the purpose of an SAI process is to understand what occurred and where necessary improve care by learning from incidents. It is very important that the Trust have full engagement with the family keeping them informed of the learning and what actions will be progressed to prevent a similar incident reoccurring.

The SAI process, both at Level 1 and Level 2 did not fully comply with the relevant policy regarding timescales, delay and appropriate engagement with the family.

The Trust should also indicate at an early juncture that a family can proceed with a complaint under the Trusts Complaint and Service User Feedback Policy and Procedure to obtain answers to concerns or complaints they may wish to make. It is possible for both SAI and Complaints procedures to be undertaken as they seek to serve different purposes, however it is preferred that one procedure is progressed at any one time with the clear and explicit communication with a family if some issues require to be "parked" for a period. The outstanding issues should be picked up at the appropriate time using the appropriate procedure. The explicit and clear communication with the family at all times is critical.

The Trust would wish to sincerely apologise to [the complainant] and the … family that the SAI investigation process was deficient in the above respects.

With regard to the resident's care, an initial Level 1 SAI investigation took place by way of a Significant Event Audit report (SEA). The Trust has reflected on the process of the SEA and acknowledges that a review team must ensure sensitivity to the needs of family involved in an incident, particularly where the family member receiving care (service user) has since passed away. The … family had sought an early meeting with the team but when the meeting took place the fact gathering had already taken place, following review of records, input from Trust and HCIL staff and the report prepared. The Trust acknowledges this was not appropriate in the

circumstances and did not adequately reflect the circumstances in this case or the need to involve the family at an early stage. Given the tight timescales involved in an SAI investigation, early engagement with the family may coincide with times of family distress including bereavement and ill health. It should not be unduly delayed as a consequence but rather handled sensitively.

In carrying out future SAI reviews the Trust will ensure that review teams provide an early opportunity for the service user/family to be involved, should they wish.

Most SAI's will enter the investigation process at Level 1, following discussion with the complainant and the family and given that they had raised a number of issues, the Trust decided to progress with a Level 2 SAI investigation by way of a Root Cause Analysis. The Trust acknowledges that the Level 2 investigation proceeded until March 2017, well outside the permitted timeframe. The Trust also acknowledge that the Level 2 engagement with the family was over a prolonged period and greater steps should have been taken to conclude matters satisfactorily. The fact that drafts of the final report reached number 18 indicate a drift that was not conducive to 'maintaining a high quality of information and documentation within a time bound process.'

CONCLUSION

10. I have the power under Section 30(1)(a) of the 2016 Act to decide to discontinue an investigation. In view of the Trust's statement set out above I have determined to discontinue this investigation on the basis that the Chief Executive of the Trust will apologise to the complainant for the failings identified above, clearly acknowledging the family's experience in a way which fully meets the requirements of my guidance on issuing an apology[5]; and will commit to an action plan outlined below.

[5] https://nipso.org.uk/site/wp-content/uploads/2018/05/N14C-A4-NIPSO-Guidance-on-issuing-an-apology-June-2016-1.pdf

11. The Trust will present an action plan to my office within 3 months outlining training to be undertaken with relevant staff involved in conducting SAI investigations to:

    (i) highlight the nature of engagement with service users and family to be achieved.

    (ii) highlight the necessity to obtain early factual information by obtaining all relevant evidence from family or front line staff and to proceed in weighing such evidence in a balanced way

    (iii) highlight the need to adhere to timescales within the SAI process

    (iv) highlight how to manage overlaps between the SAI process and complaint

    The Trust will additionally:

    (v) Highlight to relevant staff involved in commissioning and monitoring contracts with independent providers of domiciliary care services, the importance of systems for the reporting and investigation of complaints, adverse incidents and service failures.

    (vi) Review, within 6 months, the domiciliary care contract compliance process to ensure it operates to ensure the ongoing safety of service users, the operation of systems for the reporting and investigation of complaints, adverse incidents and service failures and adopt any necessary amendments in the next contracting round.

Marie Anderson **September 2018**

Ombudsman