Investigation of a complaint against Belfast Health and Social Care Trust

Report Reference: 202002119

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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

Appendix 2 – The Principles of Good Complaints Handling

Case Reference: 202002119

Listed Authority: Belfast Health and Social Care Trust

SUMMARY

I received a complaint about the actions of Belfast Health and Social Care Trust (the Trust). The complainant raised concerns regarding the Trust's investigation into the theft of his mother's (the resident) property in her nursing home (the care home) as well as its handling of an alleged incident in the care home. The complainant also raised concerns about the Trust's handling of his complaint.

The investigation examined the details of the complaint, the Trust's response, and relevant local and national guidance. It established the Trust failed to carry out all aspects of its investigation into the theft of the resident's property in line with relevant standards. It also established the Trust failed to keep sufficient records to demonstrate its adherence to relevant standards regarding its handling of the separate incident the complainant reported. The investigation also established failures in complaint handling.

On this basis, the investigation upheld each issue of complaint.

These failures caused the complainant to sustain the injustice of uncertainty, frustration, and loss of opportunity. The failures in respect of the Trust's investigation into the theft of the resident's property caused the resident to sustain the injustice of uncertainty, frustration and loss of opportunity. In addition, the failures caused the complainant to take the time and effort to bring this complaint to my Office.

I recommended that the Trust provides the complainant with a written apology within one month of the date of the final report. I made five further recommendations for the Trust to address to instigate service improvement and to prevent future reoccurrence of the failings identified - including providing my Office with an action plan regarding steps taken within six months of the date of the final report. The Trust accepted my findings and recommendations.

THE COMPLAINT

1. This complaint is about the Belfast Health and Social Care Trust's (the Trust). The complainant raised concerns regarding the Trust's investigation into the theft of his mother's (the resident) wedding ring by an employee of the nursing home (care home). The complainant also complained about the Trust's handling of an allegation when another resident threw a cup at the resident. He also complained about the Trust's handling of his complaint.

Background

2. The resident, a 94-year-old lady, lived in the care home.

3. On 16 December 2020 the care home notified the Trust that the resident reported one of its male staff members had stolen her wedding ring on 15 December 2020. The referral stated the police (PSNI) spoke with the resident, who provided a statement and a description of the perpetrator. The referral stated the care home had suspended the male staff member.

4. The Trust undertook a joint investigation[1] into the incident with the PSNI, which commenced on 17 December 2020. It met with the resident as part of its investigation on 15 February 2021 and issued its investigation report on 14 September 2021.

5. On 21 June 2021 the complainant asked the Trust to investigate a separate allegation. This was that '*sometime between*' 14 June 2021 and 17 June 2021 another resident of the care home had thrown a cup at the resident. The complainant reported it caused a bruise to the resident's leg. The Trust looked into the concern but did not refer the matter for further investigation on this occasion.

6. During the period 16 February 2021 to 9 February 2022 the complainant raised several complaints with the Trust. The Trust provided a series of responses during this period, most notably on 4 May 2021, 21 October 2021 and 17

[1] Carried out in line with the Protocol for Joint Investigation of Adult Safeguarding Cases, August 2016 – on the basis that the nature of the harm to the adult in need of protection constituted a potential criminal offence.

January 2022. The complainant was dissatisfied with the Trust's responses and so the Trust referred his concerns to my Office for consideration.

7. I understand the resident sadly passed away on 21 November 2022 during the course of my investigation.

Issues of complaint

8. The issues of complaint accepted for investigation were:

    1) **Was the investigation the Trust's Adult Protection Gateway Team conducted into the theft of the complainant's mother's wedding ring carried out in line with relevant guidance?**
    2) **Was the Trust's handling of the complainant's mother's allegation that a cup had been thrown at her by a resident reasonable, appropriate and in line with relevant guidance?**
    3) **Was the Trust's handling of the complainant's complaints reasonable, appropriate and in line with relevant standards?**

INVESTIGATION METHODOLOGY

9. 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.

Relevant Standards and Guidance

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

11. The general standards are the Ombudsman's Principles[2]:
    - The Principles of Good Administration; and
    - The Principles of Good Complaints Handling.

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

12. 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 legislation, standards and guidance relevant to this complaint are:

    - Department of Health, Social Services, and Public Safety (DHSSPS) and Department of Justice (DoJ) Policy on Adult Safeguarding: Prevention and Protection in Partnership, July 2015 (Safeguarding Policy);
    - The Health and Social Care Board (HSCB) Northern Ireland Adult Safeguarding Partnership – Adult Safeguarding Operational Procedures for Adults at Risk of Harm and Adults in Need of Protection, September 2016 (Safeguarding Procedures);
    - The Health and Social Care Board (HSCB) Protocol for Joint Investigation of Adult Safeguarding Cases, August 2016 (Joint Protocol);
    - Department of Health: Guidance in relation to the Health and Social Care Complaints Procedure (April 2019) (DOH Guidance);
    - Belfast Health and Social Care Trust (BHSCT) Policy and Procedure for the Management of Comments, Concerns, Complaints and Compliments, April 2020 (Complaints Policy); and
    - Belfast Health and Social Care Trust (BHSCT) Standard Operating Procedure on the Ongoing Management of Complaint, SOP No.4, June 2021 (Complaints SOP).

13. 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 through the exercise of professional judgment. That is unless my investigation identifies maladministration in the Trust's process of making that decision.

14. I did not include all of the information obtained in the course of the investigation in this report. However, I am satisfied that I took into account everything I considered relevant and important in reaching my findings.

15. I shared a draft copy of this report 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

Issue 1 - Was the investigation the Trust's Adult Protection Gateway Team conducted into the theft of the complainant's mother's wedding ring carried out in line with relevant guidance?

Detail of Complaint

16. The complainant raised concerns about the Trust's investigation into this incident. In particular, the following aspects:

    - The Trust's decision to interview the resident without a family member present;
    - The Trust's did not investigate why a male staff member had access to the resident on his own, when the resident's care plan states only female staff should assist her;
    - The Trust did not investigate the care home '*watching*' the male staff member at the time of the theft;
    - The Team did not investigate whether the care home had conducted pre-employment checks with that male staff member; and
    - The Team's handling of the outcome report and the complainant's comments on it.

Evidence Considered

Legislation/Policies/Guidance

17. I refer to the following policies and guidance which I considered as part of investigation enquiries:
    - Safeguarding Policy;
    - Safeguarding Procedures; and
    - Joint Protocol.

The Trust's response to investigation enquiries

18. The Trust stated its investigation was '*largely in line*' with the Safeguarding Procedures but acknowledged '*some deviations from the policy*'.

19. The Trust stated the care home referred the incident on 16 December 2020. The Trust then completed a referral to the PSNI '*for its consideration under Joint Protocol Investigation Policy*'. It appointed a Designated Adult Protection Officer [3](DAPO) and agreed with the PSNI to undertake a Joint Protocol Investigation. It informed RQIA[4] about the incident and placed an Adult Safeguarding Alert[5] on its IT system.

20. The Trust stated the DAPO and PSNI visited the resident on 15 February 2021 to obtain a statement from her, and to explain the investigation process. It explained the resident was '*unfortunately…unable to provide a statement and appeared to have poor recall of the theft of her ring*'. It conducted a meeting in respect of the investigation, together with the PSNI, on 9 March 2021.

21. The Trust stated the Team agreed to close the investigation following that meeting. It issued its final Adult Protection Investigation Report (Investigation Report) in September 2021, and had maintained '*regular*' communication with the resident and her family during the course of the investigation.

22. Regarding '*deviations*' from the Safeguarding Procedures, the Trust acknowledged there had been a '*very significant delay*' in providing the

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[3] a named person that has the responsibility for implementing and enforcing organisational safeguarding policies and procedures and overseeing the management of safeguarding concerns.
[4] The Regulation and Quality Improvement Authority - an independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland.
[5] Alert placed after a report of abuse.

Investigation Report to the resident's family. The Trust stated it apologised to the complainant for this as part of the internal complaints process.

23. The Trust stated it recorded the meeting on 9 March 2021 as a strategy meeting, but that it should have recorded this as a '*case conference*'. The '*agenda and items discussed*' are indicative of a case conference, and not a strategy meeting. It should have, therefore, conducted a strategy meeting at an earlier stage in the investigation.

24. In addition, the Trust stated it should have shared a copy of the draft Investigation Report with the resident and her family in advance of the meeting on 9 March 2021. This would have given the resident and her family an opportunity to share their '*views*' on the draft, and to '*reflect these*' at the meeting on 9 March 2021. The DAPO spoke with '*one family member*' by phone in advance of the meeting, but that the Trust had not shared a copy of the draft report.

25. Regarding pre-employment checks, the Trust stated the care home is responsible for these.

26. Regarding the decision to interview the resident without a family member present, the Trust stated the resident was mentally competent at the time, did not require family assistance and at no point asked for a family member to be present. The Trust's position was it interviewed the resident '*appropriately and sensitively*' in line with relevant standards. However, it accepted it '*should*' have '*proactively sought*' the resident's position on this prior to interviewing her.

Analysis and Findings

27. I note the Safeguarding Procedures set out six stages for the Trust to follow when it receives a referral about an adult safeguarding concern. I considered all six stages to ensure the complainant's concerns were addressed fully within the context of this guidance.

28. These are as follows:

- Stage one – screen the referral and address any immediate protection needs;
- Stage two – strategy discussion;
- Stage three – investigation;
- Stage four – implementation of the investigation report;
- Stage five – review the protection plan; and
- Stage six – close the case.

Stage one

29. *Section 10* of the Safeguarding Procedures relates to the first stage. It states the Trust must screen the referral to determine if it meets the threshold of serious harm[6] and to address any immediate protection needs.

30. I reviewed documentation relevant to this stage in the process. The care home confirmed the resident was aware of the referral. It also confirmed the resident had consented to the care home making the referral and had sufficient capacity to give that consent. It confirmed the care home had reported the incident to the PSNI and to RQIA.

31. The investigation records document the Trust screened the referral. A social worker exercised professional judgment to escalate it to the Adult Protection Gateway Team for further consideration on the basis the incident was a '*possible criminal offence*'. This is in line with *section 10* of the Safeguarding Procedures, which lists '*a potential criminal offence against the adult in need of protection*' as a '*characteristic*' likely to indicate a risk of serious harm. The Trust documented it informed the initial referrer (the care home) of its screening decision, which is also in line with *section 10* of the Safeguarding Procedures.

[6] Defined in the Safeguarding Procedures as '*a professional decision considering the impact, extent, degree, duration and frequency of harm; the perception of the person and their preferred outcome'.*

32. In terms of immediate protection needs, the Trust recorded it determined there were none at that time. Regarding its rationale, it recorded the care home had suspended the staff member in question and had involved the PSNI.

33. I am satisfied, therefore, the Trust documented both its screening decision and its consideration of the resident's immediate protection needs. It also documented its rationale for those decisions. I am satisfied the Trust's actions were in line with stage one the Safeguarding Procedures.

Stage two

34. *Section 11* of the Safeguarding Procedures relates to the second stage. It states the purpose of a strategy discussion is to '*to address any potential conflicts between agencies at an early stage*' and to '*provide the opportunity for clarification of roles and responsibilities in relation to HSC Trust, PSNI, RQIA and where applicable an employing organisation*'.

35. *Section 11.5* states the strategy discussion '*must demonstrate*' the Trust has reviewed the screening decision. It must demonstrate the Trust has considered the adult's human rights, their capacity to make decisions, and their wishes regarding the process. It states as part of this meeting the Trust must determine whether the investigation into the incident will be a single investigation by the Trust, or a joint investigation with the PSNI. The Trust must then agree an investigation plan, setting out who will be involved, timescales, and a communication strategy. This section states the Trust must take minutes of the meeting, and then circulate them with the attendees.

36. *Section 11.3* states it is '*good practice*' for a strategy discussion to take place '*as soon as possible*'.

37. I note the Trust's acknowledgement that it did not convene a strategy discussion at the initial stage of its investigation, and its admission that it should have done so. I also note the Trust's explanation it had incorrectly categorised the document entitled '*Minutes of Strategy Meeting 9 March 2021*' – and that this was a record of a case conference, rather than a strategy discussion.

38. Upon review of the documentation, I am satisfied the Trust did consider some of the matters required by *section 11.5* at this early stage in the process. The Trust documented there were no concerns regarding the resident's mental capacity. It documented its consideration of the resident's human rights. It also documented its decision to proceed with a joint investigation with the PSNI, and its rationale for this decision. *Section 1.1* of the Joint Protocol states it is appropriate to proceed with a joint investigation where '*the nature of the harm to the adult in need of protection constitutes a potential criminal offence*'. The DAPO exercised their professional judgment in deciding to proceed with the joint investigation.

39. However, the records do not document a review of the screening decision. They do not document the resident's specific wishes regarding the process or what consideration the Trust gave to these. The records do not document an investigation plan establishing timescale, separation of roles, an investigative approach and a communication strategy. As a result, the Trust failed to ensure, from the outset, a defined structure for the investigation. As a result, I consider the Trust failed to fully adhere to *section 11* of the Safeguarding Procedures in this respect.

40. The first Principle of Good Administration, '*getting it right*', requires a public body to adhere to relevant policies and standards and to take account of established good practice. In addition, the third Principle of Good Administration '*being open and accountable*', requires a public body to keep proper and appropriate records, to state criteria for decision-making and to give reasons for decisions. I consider the Trust failed to adhere to these Principles when it failed to adhere to stage two of the Safeguarding Procedures.

Stage three

41. The Joint Protocol and *Section 12* of the Safeguarding Procedures relate to stage three of the process. I note the PSNI were involved in this investigation from the outset. Therefore, the Trust's decision to proceed with a joint investigation under the Joint Protocol was formalisation of a process already commenced. I note the PSNI therefore had the lead role in the joint

investigation. S*ection 11.1* of the Safeguarding Policy recommends this. *Section 3.4* of the Joint Protocol also allows for this. In these circumstances, this section sets out the Trust's role in the process. The Trust is responsible for co-ordinating any joint agency[7] meetings required and ensuring '*close liaison and communication*' between the Trust and the PSNI. The Trust is also responsible for assessing matters relating to consent, capacity and human rights, as well as keeping risk of harm under review. *Section 12.1* of the Safeguarding Procedures states the Trust can meet with an adult as part of the investigation. *Section 3.4* of the Joint Protocol permits the Trust and the PSNI to jointly meet with an adult.

42. Both the Joint Protocol and the Safeguarding Procedures establish that the DAPO has an oversight role in the investigation process. They establish it is an investigation officer working alongside the DAPO that carries out the substantive elements of the investigation. On review of the investigation documentation, it is apparent the Trust appointed an investigation officer to support the DAPO. However, it is also apparent that on this occasion, it was the DAPO who was primarily involved in the substantive investigation on the part of the Trust. This is not the DAPO's typical role. However, I am satisfied the Safeguarding Procedures do not specifically preclude the DAPO from taking on the substantive role.

43. I note the complainant did not raise concerns about the Trust's decision to proceed with a joint investigation, or with the PSNI's involvement, or the DAPO's role. However, he raised the following concerns about this stage of the process:

    - The Trust's decision to interview the resident alone on 15 February 2020;
    - What the Trust considered in the investigation; and

[7] To include the Trust and the PSNI, as well as potentially RQIA, and other interested parties, such as care home representatives.

- The Trust's timescale in issuing the investigation report, and its handling of his comments on it.

Interview on 15 February 2021

44. I note the Trust documented in the investigation records that the DAPO and the PSNI tried to obtain further information from the resident regarding the incident. The record documents the resident '*did not appear to have any recall of the reported incident*'. The record also documents the DAPO and the PSNI decided '*it would have been non-productive to pursue*'. I note the PSNI proceeded with the information it had already obtained, and that a court ultimately convicted the male staff member.

45. The complainant was concerned about the Trust's decision to conduct this interview without a family member present. The Joint Protocol sets out that the Trust should consult with an adult's family where it has determined the adult lacks capacity to make decisions relating to the investigation. *Appendix 7* of the Joint Protocol and *section 7.5* of the Safeguarding Procedures set out the Trust should treat an adult as having capacity to make decisions '*unless there is contrary information*'. S*ection 12.2* of the Safeguarding Policy echoes this standard.

46. In the investigation documentation the Trust recorded considering the resident's capacity across its interactions with her during the investigation. The Trust recorded the patient had sufficient capacity at the time the interview took place. Having reviewed the investigation documentation, I am satisfied the DAPO considered the resident's inability to recall the incident at the time of the interview. The DAPO exercised their professional judgment to determine this did not equate to a lapse in her capacity or mental competency. In the records, the Trust documented the resident could suffer from urinary tract infections (UTIs) that could temporarily impact her mental state at times. Upon review of the social work records there is no indication the resident was suffering from an UTI at the time of this interview.

47. On this basis, I am satisfied the Trust's decision to interview the resident without a family member present was in line with relevant standards. However,

I note the Trust's acknowledgement in its response to my Office that it could have consulted with the complainant to notify him the interview was to take place, and to explore whether he wanted to be present. I share this view and would urge the Trust to adopt this approach moving forward, to improve the experience of this challenging process for residents and their families.

What the Trust considered in the investigation

48. The complainant said there was nothing in the investigation report to demonstrate the Trust considered the following issues during its investigation:

    - Why a male staff member had access to the resident on his own;
    - The care home '*watching*' the male staff member at the time;
    - Whether the care home had conducted pre-employment checks with that male staff member

49. *Section 12* of the Safeguarding Procedures sets out the Trust should seek to *'establish the facts and contributing factors leading to the referral*' and '*determine and manage the level of risk to an adult in need of protection and or others and update the care and protection plan as required*'. It should then produce an investigation report. The Joint Protocol sets out it is the Trust's role in the joint investigation to manage ongoing risk to the resident and others in the care home.

50. I refer to the complainant's concern about a male staff member having access to his mother. Upon my review of the investigation documentation, the DAPO recorded the resident's care plan was clear only female staff members should attend to her needs. The DAPO recorded that because of this, the resident did not know who the male staff member was when he entered her room. The DAPO also included this information in the investigation report.

51. There is no indication in the investigation documentation the Trust specifically investigated why the male staff member had been able to enter the resident's room. There is no indication the Trust examined the care home rotas to check if the care home had assigned the male staff member to the resident that day,

contrary to the resident's care plan. This would have been an important consideration in establishing the facts leading to the referral, as well as determining and managing risk to the resident, and others in the care home. Whilst it may have transpired the male staff member acted outside of the established care plan and rotas that day, it cannot be determined from the investigation conducted. I consider the Trust ought to have included this in its investigation to ensure compliance with *section 12* of the Safeguarding Procedures.

52. I refer to the complainant's concern about the care home '*watching*' the male staff member. The investigation documentation includes a record of the care home manager informing the Trust it had been '*watching*' this individual. There is no reference to this in the investigation report. There is no indication in the investigation documentation the Trust specifically investigated why this was the case. I consider the Trust should have investigated this detail further with the care home to comply with *section 12* of the Safeguarding Procedures. I consider it to be important in establishing the facts leading to the referral. It speaks to whether there the care home was in possession of information that could have prevented the incident occurring. I also consider it would have been important in determining risk for residents going forward in terms of the approach the care home takes to monitoring staff it has concerns about.

53. I refer to the complainant's concern about the care home's pre-employment checks. There is no indication in the investigation documentation that the Trust considered this issue. I note the Trust's position pre-employment checks are a matter for the care home. I accept it is the care home's responsibility to perform these checks. However, I consider the Trust should have investigated whether the care home had carried out its pre-employment checks appropriately in respect of this staff member as part of this investigation, to ensure compliance with *section 12* of the Safeguarding Procedures. I consider this also to be important in establishing the facts leading to the referral and determining risk to the resident. It is relevant to whether the care home could have potentially prevented the incident taking place.

54. As a result, I consider the Trust failed to adhere to the first Principle of Good Administration (set out above) that requires public bodies to adhere to relevant policies and standards and to take account of established good practice when it failed to fully adhere to *section 12* of the Safeguarding Procedures. I also consider the Trust failed to adhere to the third Principle of Good Administration (also set out above) that requires public bodies to handle information '*properly and appropriately*'.

55. I refer to my earlier finding in respect of the Trust's failure to put an investigation plan and structure in place at stage two of the process. I consider the failures identified regarding stage three of the process may have been minimised or avoided had the Trust completed stage two in line with relevant standards.

Stage 4

56. *Section 13* of the Safeguarding Procedures relates to the Trust sharing the draft investigation report and conducting a case conference. *Section 13.1* states the DAPO should conduct a case conference once the Trust and the PSNI have completed their investigation. *Section 13.2* states that at the case conference, the attendees should consider the information in the investigation report, analyse the findings and decisions made. The attendees should consider the evidence gathered, consider any ongoing risks to the adult, and agree any ongoing protection plan.

57. I note the Trust's explanation that the meeting it conducted on 9 March 2021 was a case conference, and not a strategy meeting as they had entitled it. I reviewed the minutes of this meeting and am satisfied the items discussed were those required by *Section 13.1* of the Safeguarding Procedures. I am satisfied, therefore, the Trust did conduct a case conference following the conclusion of its investigation.

58. *Section 13.2* of the Safeguarding Procedures states the Trust should share a copy of the draft investigation report with the adult and their family in advance of the case conference. It states this is to allow the adult and their family an

opportunity to present their views on the report, so attendees can discuss them at the case conference.

59. The complainant said he did not receive a copy of the report until 22 September 2021, and that this was the final report. The complainant said he did not have the opportunity to discuss the investigation or the report with the Trust. The Trust acknowledged in its response to my Office that it did not share a copy of the draft report with the resident or with the complainant – either before or after the case conference. The Trust accepted this was a '*deviation*' from the Safeguarding Procedures, and I agree.

60. The Trust only provided the final report to the complainant, at which stage the Trust had closed the investigation. This failure meant both the resident and the complainant were unable to review the draft report, provide their views on it, and have the Trust review their input in the context of the investigation prior to its closure. If the Trust had shared a copy of the draft report in line with the Safeguarding Procedures, the complainant could have had the opportunity to raise the concerns he brought to my Office regarding the investigation. This would have allowed the Trust to address these issues at the time, within the parameters of the investigation.

61. In addition, the Trust acknowledged in its response to my Office there was a '*very significant delay*' in providing the final investigation report to the resident and the complainant. I note the Trust acknowledged this during the internal complaints process and apologised to the complainant for this.

62. I consider the Trust failed to adhere to the first Principle of Good Administration (set out above) in this respect. This principle requires public bodies to not only adhere to relevant policies and standards, but also to act '*with regard to the rights of those involved*'. I consider the Trust failed to have regard for the resident and the complainant's rights to participate fully at stage four of the investigation process.

63. I refer again to my earlier finding in respect of the Trust's failure to put an investigation plan and structure in place at stage two of the process. I consider the failures identified regarding stage four of the process may have been

minimised or avoided had the Trust completed stage two in line with relevant standards.

Stages 5 and 6

64. *Section 14* of the Safeguarding Procedures relates to a review of an adult's protection plan following conclusion of the investigation. The purpose is to determine if any changes need to be made because of the investigation.

65. *Section 15* of the Safeguarding Procedures relates to closing the investigation. It states the Trust may close the case where they decide no further investigation is needed.

66. Upon my examination of the investigation documentation, I note the DAPO reviewed the resident's protection plan on 13 May 2021, following the case conference. The DAPO recorded a court had convicted the male staff member of the theft of the resident's wedding ring. The DAPO also recorded the male staff member had resigned from his employment with the care home and could not obtain a similar job elsewhere for six months. The DAPO recorded that, on this basis, there was no ongoing risk to the resident, and so closed the investigation.

67. I have already addressed the Trust's delay in concluding the investigation process and noted their acknowledgement of this. However, I am satisfied the DAPO recorded their review of the resident's protection plan, and their rationale for closing the investigation in the investigation documentation. I am satisfied, therefore, the Trust acted in accordance with the Safeguarding Procedures in respect of these stages in the process.

Summary

68. I found the Trust adhered to the Safeguarding Procedures at stages one, five and six of the investigation process. However, I also found it failed to adhere to this guidance at stages two, three and four of the investigation process. I consider, therefore, the Trust failed to carry out its full investigation in line with

relevant standards. In failing to do so, I consider the Trust failed to adhere to the First and Third Principles of Good Administration (set out above).

69. I consider these failures constitute maladministration. They caused the resident and the complainant to sustain the injustice of uncertainty and frustration regarding the investigation process. They also caused the resident and the complainant to sustain the injustice of loss of opportunity to contribute fully to the investigation process. I therefore uphold this element of the complaint.

70. Notwithstanding my findings, I am satisfied that, on balance, the failings did not give me cause to question the Trust's exercise of professional judgment during the joint investigation. I am satisfied the outcome of the joint investigation would have been the same as if the failings had not occurred. This is because the home suspended the male staff member, who subsequently resigned and was convicted of the crime. The PSNI also recovered the resident's ring and returned it to her.

Issue 2 - Was the Trust's handling of the complainant's mother's allegation that a cup had been thrown at her by a resident reasonable, appropriate and in line with relevant guidance?

Detail of Complaint

71. The complainant said he raised this concern with the Trust, but the Trust did not sufficiently investigate.

Evidence Considered

Legislation/Policies/Guidance

72. I refer to the following policies and guidance which I considered as part of investigation enquiries:
    - Safeguarding Policy; and
    - Safeguarding Procedures.

The Trust's response to investigation enquiries

73. The Trust stated it correctly applied the Safeguarding Procedures to this incident. The complainant sent his concern to a lead nurse who arranged for a senior social worker to visit the resident in the care home.

74. The Trust explained the senior social worker did so and '*observed*' the resident's leg. The senior social worker spoke with the care home manager, who said she was not aware of the incident. The senior social worker asked the care home manager to send her photographs of the resident's leg, and to speak with staff about whether they had witnessed the incident. The care home manager provided the senior social worker with the photographs. She confirmed she had spoken with staff, and no one had been aware of this incident.

75. The Trust stated the senior social worker determined there was '*no evidence*' the incident took place, and '*no evidence*' of any injury. The senior social worker therefore determined further investigation was not necessary. The lead nurse communicated this to the complainant on 24 June 2021.

Analysis and Findings

76. I note *section 10* of the Safeguarding Policy and *section 6* of the Safeguarding Procedures relate to the Trust's responsibilities when initially responding to an adult safeguarding concern.

77. Upon receipt of a concern, the Safeguarding Policy requires social workers to assess whether an adult is at risk of harm, and whether the concern meets the threshold for an adult protection intervention. The Safeguarding Policy states '*the assessment will inform a proportionate response based on the views and wishes and the preferred outcomes of the individual*'.

78. Both pieces of guidance require social workers to use their professional judgment in considering these issues and provide criteria to assist social workers in their exercise of this judgment. These criteria include consideration of the impact of an incident on an adult's health and well-being, the adult's

perception of the incident, and whether the incident was committed with '*deliberate and harmful intent*'.

79. I reviewed all relevant documentation. The Trust's records document the complainant contacting the lead nurse. The records also document the lead nurse subsequently informing the complainant about the senior social worker's visit on 23 June 2021, and the conclusion there was no evidence to suggest the incident took place. The records document the care home manager providing the photographs the senior social worker requested and confirming the manager had spoken to staff on duty about the complainant's concern. They also document the care home manager confirming staff had no '*recollection*' of the incident.

80. However, the documentation does not include the senior social worker's record of her visit to the care home that day, or the full discussion she had with the care home manager. I also note the Trust's position the senior social worker spoke with the resident and '*observed*' her leg. I asked the Trust to provide me with records in respect of this visit that would document the senior social worker's actions that day.

81. In response to my queries, the Trust explained the records it provided showed the lead nurse recording the senior social worker's visit. It explained they document the Trust informing the complainant of what it had discovered and concluded about the incident. The Trust explained *'there was not a separate recording made by [the senior social worker] of the visit as it was already being recorded by [the lead nurse] on the PARIS records*'.

82. I am satisfied from the records available the senior social worker visited the resident on 23 June 2021 and spoke with the care home manager about the incident. I am further satisfied the senior social worker asked the care home manager to seek and provide additional information to inform her consideration of the complainant's concern. I consider that, on receipt of that information, the senior social worker exercised her professional judgment to decide no further investigation was necessary. This was due to the lack of evidence of the incident occurring.

83. However, I consider the senior social worker should have kept a record of her visit to the care home on 23 June 2021. She should have kept a record of the discussion she had with the care home manager and with the resident. The Trust's records show the lead nurse communicating the outcome to the complainant, but they do not show the senior social worker's rationale for deciding not to investigate further. A record of her rationale is necessary to show how the social worker exercised her professional judgment. I consider this is necessary to show how she complied with the Safeguarding Policy and the Safeguarding Procedures.

84. The third Principle of Good Administration '*being open and accountable*', requires a public body to keep proper and appropriate records, to state criteria for decision-making and to give reasons for decisions. I consider the Trust failed to adhere to this Principle regarding its record-keeping.

85. I consider the failures in record keeping constitute maladministration. I am satisfied they caused the complainant to sustain the injustice of loss of opportunity to satisfy himself of the rationale for the senior social worker's decision regarding this incident. They also caused the complainant to sustain the injustice of uncertainty regarding the Trust's handling of this incident.

86. I therefore uphold this issue of complaint.

87. However, I do not consider these failures caused me to question the Trust's exercise of professional judgment in deciding not to investigate further. The evidence the care home provided to the Trust did not demonstrate facts from which it could reasonably be determined the incident had occurred.

Issue 3 – Was the Trust's handling of the complainant's complaints reasonable, appropriate and in line with relevant standards?

Detail of Complaint

88. The complainant raised concerns about the Trust's handling of the following:

- His complaint dated 16 February 2021;

- His concerns raised during a meeting on 20 April 2021; and
- His connected complaints raised during the period July 2021 to September 2021.

89. I reviewed all relevant documentation and compiled a detailed chronology of the timeline of these complaints, and the Trust's handling of them.

90. Regarding the complaint of 16 February 2021, the complainant raised concerns that:

    - The Trust did not adequately communicate with him about who was involved in the investigation of his complaint as it progressed; and
    - The Trust did not adhere to its timescale for investigation of his complaint. In addition, it did not provide updates on progress and estimated timeframes for resolution of his complaint.

91. Regarding the meeting on 20 April 2021, the complainant raised concerns that:

    - The Trust did not adequately communicate with him about how it progressed his concerns regarding aspects of the resident's care in the care home; and
    - The Trust did not adhere to its timescale for investigation of his complaint or provide sufficient progress updates regarding his complaint about the Trust.

92. Regarding the connected complaints he raised during July 2021 to September 2021, the complainant raised concerns that:

    - The Trust did not adhere to its timescale for investigation of his complaint or provide sufficient progress updates. In addition, it did not provide an acceptable explanation for its delays in resolving his complaints;
    - The Trust did not address all the concerns he raised, and would instead '*cherry pick*' matters. In particular: (1) lack of contact following the

meeting on 20 April 2021; (2) queries regarding its CCTV policy; (3) obtaining and use of his private telephone number, despite stated objections; (4) the Trust's knowledge of the care home staff member who stole the resident's wedding ring; and (5) handling of a separate investigation into an incident where the resident was injured by a care home staff member; and

- The Trust's decision to refer his complaint to my Office was premature.

93. In addition, the complaint concerned whether the Trust sufficiently clarified the position regarding top-up payments for the resident's care home, and adequately communicated this to be complainant.

Evidence Considered
Legislation/Policies/Guidance

94. I refer to the following policies and guidance which I considered as part of investigation enquiries:
    - DOH Guidance;
    - Complaints Policy and
    - Complaints SOP.

The Trust's response to investigation enquiries

95. Regarding timeframes, the Trust accepted it did not always acknowledge receipt of the complainant's correspondence within two working days. The Trust stated it apologised for this as part of the internal complaints process. It explained that, at times, it would acknowledge several emails at once, and that this was due to '*capacity restraints*' and the '*volume of emails received*' from the complainant. The complainant was dissatisfied with that approach.

96. Regarding fully responding to the complainant's concerns, the Trust stated it '*attempted*' to address all the concerns raised. It had acknowledged shortcomings in its actions and apologised for these in its responses to the

complainant. It acknowledged the complainant had remained dissatisfied with its explanations. The Trust denied it '*cherry-picked*' issues to respond to.

97. Regarding its referral to my Office, the Trust denied it had been premature. The Trust explained it decided to refer to matter because it has been '*unable*' to provide the complainant with '*the necessary assurances to fully resolve and address*' his complaints. The complainant '*continued to raise issues which were previously addressed*' and that '*no further response could be provided*'.

98. Regarding the top-up fees issue, the Trust stated the complainant had to first seek a refund from the care home directly. It would only become involved if the parties could not resolve the issue. It explained this to the complainant in its response dated 4 May 2020. The complainant challenged the Trust's position on this. The complainant said the Trust did not explain how he could obtain a refund, but rather explained it could assist him to reach a solution with the care home.

Analysis and Findings

Complaint of 16 February 2021

99. I reviewed all relevant documentation. The Trust, in its response to the original complaint dated 21 October 2021, accepted the staff member the complainant directed his complaint to did not acknowledge it. It further accepted the staff member who did acknowledge it did not do so until almost four weeks after the complainant submitted it. In addition, the Trust accepted it had not explained what was happening to the complainant.

100. The Trust accepted these actions fell short of the standards it should have provided and apologised to the complainant as part of the internal complaints process. I consider it was reasonable and appropriate for the Trust to have done so.

101. I note the Trust's complaints department acknowledged receipt of this complaint on 11 March 2021. It provided its response on 4 May 2021. This is outside the timescale for resolution of 20 working days in the DOH Guidance

and in the Complaints Policy. The DOH Guidance states that where the Trust is unable to respond to a complaint within this timeframe it must ensure it updates the complainant at least monthly about its progress, and of an anticipated timeframe for resolution.

102. I note the Trust updated the complainant on 23 March 2021 and provided an updated timeframe for resolution. On 13 April 2021 the Trust informed the complainant there would be a further delay in responding to his complaint. However, on this occasion it gave no update on the progress of the investigation, and no estimated timeframe for resolution. In its response of 17 January 2022, the Trust acknowledged it did not agree a plan with the complainant to maintain regular contact and apologised for this. However, the Trust did not acknowledge or apologise for giving no meaningful investigative updates or estimated timeframes during this period in that letter. The Trust did not adhere to the DOH Guidance or the Complaints Policy in this respect, which I consider to be a failure in complaint handling.

Concerns of 20 April 2021

103. At the meeting on 20 April 2021 the complainant raised a variety of concerns. Some of these concerns related to how the care home had been treating the resident. Others related to the Trust's own actions specifically.

104. I refer to the concerns about the care home. *Paragraphs 2.33 – 2.35* of the DOH Guidance relate to a complaint about a residential or nursing home. These paragraphs state the Trust can either investigate concerns of this type itself or refer the matter to the home to investigate directly. The Trust must inform a complainant how it intends to proceed.

105. I reviewed the minutes of the meeting. The complainant raised a variety of concerns, including the placement of furniture in the resident's room, the cleanliness of the room, and a buzzer being present in the room. The complainant provided the Trust with two diaries in which he had recorded concerns. The Trust agreed action plans with the complainant in that meeting to resolve these issues moving forward.

106. I am satisfied, therefore, the Trust undertook to address these concerns itself. This was in line with the DOH Guidance. However, it is apparent from the documentation provided that the Trust did not provide the complainant with meaningful updates regarding its handling of these concerns. The complainant sought confirmation from the Trust that it had reviewed the diaries he provided. I am satisfied the Trust did not provide this to the complainant. The complainant was therefore unaware of what actions, if any, the Trust was taking to look into his concerns. The lack of meaningful communication was a source of frustration for the complainant. I consider the Trust's failure to provide meaningful updates and responses constitutes a failure in complaint handling.

107. I refer to the concerns about the Trust specifically. I note the Trust acknowledged receipt of those concerns in the meeting itself. However, it is apparent the Trust did not treat these concerns as a complaint against it until 13 July 2021, nearly three months later. The DOH Guidance and the Complaints Policy state the importance of staff recognising when an individual is raising a complaint, and taking appropriate action. I accept the complainant raised many issues in that meeting, and that not all of them were about the Trust's actions specifically. However, the Trust has a responsibility, in line with both the DOH Guidance and the Complaints Policy, to sufficiently train its staff to recognise complaints. This guidance requires the Trust to train staff to identify when to process a concern under its Complaints Policy, and to appropriately escalate it.

108. By failing to appropriately identify aspects of the complainant's concerns as a complaint against itself, the Trust failed to follow relevant standards in its handling of these concerns. As a result, it failed to provide the complainant with a response to his concerns within 20 working days. It provided no updates to the complainant regarding its handling of these concerns, as required by those standards. Furthermore, the Trust failed to provide the complainant with any anticipated timescales for resolving these concerns until 14 July 2021.

109. I accept that once the Trust's complaints department became involved, it took steps to amalgamate all the complainant's concerns and address them all together. However, by this stage the complainant was beginning to lose

confidence in the Trust's complaints handling. I consider the complainant's feelings in this respect were justifiable.

110. I consider this to be a failure in complaints handling on the Trust's part.

Connected complaints of July 2021 – September 2021

111. I reviewed all relevant documentation. However, the following are of particular relevance:

- 13 July 2021 – the Trust informed the complainant it would be forwarding his concerns stemming from the 20 April 2021 meeting to its complaints department;
- 14 July 2021 – the Trust informed the complainant the complaint department would now be looking into his concerns, and identified a point of contact for him going forward;
- 15 July 2021 – the complainant provided the Trust with a full breakdown of his complaints. This included concerns about how the Trust handled his complaint on 16 February 2021, as well as the concerns he had raised on 20 April 2021. This also included additional concerns relating to the Trust's actions. The Trust acknowledged these on 16 July 2021;
- 18 July 2021 – the complainant raised some additional concerns. The Trust acknowledged these on 20 July 2021;
- 27 August 2021 – the complainant raised a further complaint, specifically about the complaint's department's handling of his complaints to date. The complainant expanded on this further on 30 August 2021 and on 1 September 2021. Whilst there was communication between the Trust and the complainant following 1 September 2021, the Trust did not formally acknowledge this complaint until 23 September 2021;
- 22 September 2021 – the complainant raised a complaint about the contents of the investigation report into the theft of the resident's wedding ring;

- 21 October 2021 – the Trust issued its response to the complaints it received that were not related specifically to its complaints department. The Trust said it would respond to the complainant's additional complaints separately;

- 7 January 2022 – the Trust issued its response to concerns the complainant had raised on foot of its previous response on 21 October 2021. The Trust informed the complainant it would respond to his outstanding complaints against its complaints department separately;

- 17 January 2022 – the Trust issued two final response letters to the complainant; and

- 7 February 2022 – the Trust referred the matter to my Office. It informed the complainant of this on 9 February 2022.

Trust's acknowledgment of correspondence

112. The DOH Guidance and the Complaints Policy state the Trust should do so within two working days of receipt. The guidance is clear this timeframe relates only to the acknowledgement of specific complaints.

113. It is clear from the documentation that several of the complainant's correspondence related to new complaints, or new elements to existing complaints. The Trust was required to adhere to the timeframe in the relevant guidance in this respect. The Trust acknowledged during the internal complaints process that there were occasions where it failed to adhere to this timeframe. The Trust apologised to the complainant for this during the internal complaints process, which was reasonable and appropriate for it to do.

114. It is also clear from the documentation that several of the complainant's correspondence did not raise new complaints or expand on existing ones. Instead, the complainant was seeking updates from the Trust regarding the investigation, including seeking answers to specific questions to do with the investigation process. The DOH Guidance and the Complaints Policy require the Trust to communicate effectively and efficiently with the complainant during

the investigation. However, they do not require the Trust to respond to those types of queries within two working days specifically.

115. I consider, therefore, there were occasions where the Trust failed to adhere to the DOH Guidance and its Complaints Policy in this respect. However, I am satisfied the Trust has already acknowledged this failure and apologised to the complaint for it as part of the internal complaints process.

Timeframe of the Trust's responses, and its investigation updates

116. The DOH Guidance, Complaints Policy and the Complaints SOP each state the Trust should respond to a complaint within 20 working days of receipt. The relevant guidance states that where the Trust is unable to meet this timeframe, it must inform the complainant as soon as possible. It must provide an explanation for the delay and indicate the timeframe within which it is '*likely*' to provide its response. The Trust must provide such an update at least every 20 working days during the investigation.

117. It is clear from the documentation that a large volume of correspondence passed between the complainant and the Trust during this period. A significant proportion of the complainant's emails were him seeking updates from the Trust about the progress of its investigation and querying why the Trust continued to delay. I consider there were occasions where the Trust failed to provide the complainant with timely updates in respect of the investigation in line with relevant guidance. It also failed to provide the complainant with formal responses within the 20 working day timeframe. However, I am satisfied the Trust has already acknowledged these failures and apologised to the complaint for them as part of the internal complaints process.

118. However, on review of the documentation, I consider there were occasions where the Trust's updates to the complainant did not include sufficient detail in respect of the reasons for their delays. The Trust discussed the impact of the COVID-19 pandemic, staff pressures and holiday periods as reasons for delay in its formal responses. However, this information came at the conclusion of the processes, rather than as part of periodic updates during the investigation. This

meant the Trust was updating the complainant that its response was delayed, but not providing sufficient reasons for it as the investigation proceeded.

119. In addition, I consider that in the Trust's updates to the complainant, it consistently failed to provide a '*revised timescale within which the complainant can expect a response*'.

120. As a result, the Trust failed to meet the requirements of the DOH Guidance, its Complaint Policy and its Complaints SOP in these respects. The Trust did not acknowledge or apologise for this during the internal complaints process.

121. I appreciate the complaints department was under pressure during this time-period due to the impact of the COVID-19 pandemic, as with all areas of the health and social care sector. I also appreciate the complainant corresponded frequently with the Trust during this period. This correspondence included new complaints, specific queries, and requests for updates about ongoing complaints. I appreciate the Trust attempted to handle these new complaints alongside addressing existing ones, with the intention of providing a consolidated response. I also appreciate the complainant had raised several issues during this time, some of which required input from a variety of personnel. The complainant was keen to ensure the Trust maintained its communication with him in line with its Complaints Policy. I appreciate this was, at times, challenging for the Trust.

122. However, I noted earlier in this report that by July 2021 the complainant had started to lose confidence in the Trust's complaints handling, and that I considered there was justification in him feeling that way. It is apparent that as time continued to pass the complainant began to lose patience with the Trust, and that he became exasperated. I consider the complainant's feelings were understandable.

123. I consider the Trust took steps to try and resolve the various complaints in as structured a manner as possible in challenging circumstances. Having reviewed the Trust's complaints file, I can see the complaints department worked extensively to try and resolve the complaints during this period. Nonetheless, the Trust failed to adhere to the DOH Guidance and its Complaints Policy

regarding timescales and communication with the complainant often during this period. I consider this further exacerbated the complainant's feelings of frustration.

'Cherry-Picking' of concerns

124. The DOH Guidance and the Complaints Policy require the Trust to '*aim to*' address all elements of complaints it receives, and to respond fully to each.

125. Regarding the Trust's lack of contact following the meeting on 20 April 2021, the complainant sought an explanation for this. The Trust acknowledged it delayed in providing the complainant with a copy of the minutes of this meeting and apologised for this. However, I do not consider it sufficiently addressed the reason for lack of communication on the concerns raised between April 2021 and July 2021. I also do not consider it provided a sufficient explanation for this. I consider this Trust should have done so in its response.

126. Regarding the CCTV issue, the Trust said the complainant should approach the care home for this information. I accept the care home likely had its own CCTV policy. I note the complainant's comment that he sought the Trust's input because he did not receive a response from the care home. The complainant considers the Trust should therefore have sought to resolve this query in the care home's stead. Whilst I understand the complainant's frustration in this respect, I am nonetheless satisfied it was correct for the Trust to advise the complainant to approach the care home for a copy of the care home's own policy. I am satisfied the care home's CCTV policy is not within the remit of the Trust. However, the complainant also asked for a copy of the Trust's specific CCTV policy. The Trust did not provide the complainant with a copy of this or signpost him to where he might be able to obtain a copy. I consider the Trust should have done so to address this element of the complaint. If no such policy exists, I consider the Trust should have been clear about this with the complainant.

127. Regarding the Trust's use of the complainant's private telephone number, the Trust acknowledged the resident's key worker made several calls to the complainant's private number. The Trust also acknowledged this staff member

obtained that number from the care home. However, the complainant raised specific concerns about how the Trust had allowed that staff member to obtain his number that way, and why she had continued to contact him on it despite his objections. I consider the Trust did not sufficiently address these concerns in its responses, despite this being a prominent issue in the complaints it received. I consider the Trust should have done so.

128. Regarding the Trust's knowledge about the care home's surveillance of the staff member who stole the resident's ring, I note the complainant raised this on several occasions. Whilst it would have been preferable for the Trust to address this issue more efficiently, I am satisfied it confirmed it had no prior knowledge of this matter prior to 16 December 2020. I am satisfied, therefore, the Trust did sufficiently address this matter during the complaints process.

129. Regarding the Trust's investigation of the resident's physical injury, the complainant raised several specific concerns about the Trust's investigation process and outcome. I accept the complainant was dissatisfied with the responses he received. However, I am satisfied the Trust took reasonable steps to address these concerns in its responses on 21 October 2021, and later on 7 January 2022.

130. I appreciate the complainant raised a large volume of concerns during this period. The complaint was entitled to do so, and there is no suggestion any of these concerns were invalid. However, I appreciate it was challenging for the Trust to ensure it responded fully to each element of each of the complaints.

131. It is apparent from the documentation that the Trust put a lot of time and effort into addressing the complaints, and its responses were clear and detailed, as required by the DOH Guidance and its Complaints Policy. I am satisfied that, for the most part, the Trust provided responses to the complainant's concerns. However, I consider there were elements of the complaints the Trust failed to fully address. I consider this to be a failure to adhere fully to the DOH Guidance and its Complaints Policy, and therefore a failure in complaints handling.

Referral to my Office

132. The Trust's Complaints Policy details its obligation under *Section 25* of the Public Services Ombudsman Act (NI) 2016 to proactively signpost a complainant to my Office where it considers the complainant has received a final response to their complaint. This allows the complainant to approach my office and ask for their complaint to be investigated. *Section 6* of the 2016 Act allows a public body to refer a complaint to my Office where that body has been unable to resolve that complaint.

133. I appreciate the complainant's position that the Trust referred this matter to my Office despite issues he felt remained outstanding. However, I have noted above it is apparent the complainant lost confidence in the Trust's handling of his complaints, that he had begun to lose patience with the Trust and had become frustrated and exasperated. I have also set out above that I consider it understandable in the circumstances for the complainant to feel this way. I also consider that by February 2022, the complainant's feelings were apparent to the Trust. Within this context, I am satisfied the Trust's decision to refer this matter to my Office at that stage in the process was reasonable and appropriate, and in line with both the Complaints Policy and the legislation governing my Office.

Top-up concern

134. On 16 February 2021 the complainant informed the Trust he '*withdrew*' from paying the top-up fee for the resident's nursing home placement on 19 December 2020. He explained he would not re-start paying the fees until the Trust has resolved the concerns he raised about the resident's care in the home.

135. In its response dated 4 May 2021, the Trust informed the complainant it could assist him and the care home to resolve the fees issue. However, the complainant would have to first seek a resolution with the care home directly. The Trust acknowledged the complainant's position he felt he could not resolve this matter until the Trust concluded its investigation into the theft of the resident's wedding ring.

136. The complainant continued to raise concerns about the resident’s care that undoubtedly influenced his ongoing decision to withhold the top-up fees. However, neither party raised the existence or payment of the fees in the subsequent complaints during the period July 2021 to September 2021.

137. The DOH Guidance and the Complaints Policy require the Trust to ‘*aim to answer all the issues raised by the complainant, in an open and honest way, explaining the situation, why it occurred and the action taken or proposed action*’.

138. I appreciate the top-up fee issue was multifaceted. Resolution required input from the complainant and the care home as well as from the Trust. It remained unresolved following the conclusion of joint investigation process in September 2021, and following the Trust’s referral of this matter to my Office in February 2022.

139. In the complaint, the complainant did not raise a concern about how or why he was paying a top-up fee. Instead, he wanted to ‘*place a few things on record*’ about why he had chosen to stop paying the fee. In the Trust’s response, it did not challenge the complainant on this decision. Instead, it set out its role in seeking to resolve the matter in relation to the care home’s role.

140. I note resolution of the concerns that caused the complainant to stop paying the top-up fees remained outstanding for a considerable period of time. The Trust has recognised aspects of its input into its delay in resolving these concerns. I have outlined some further concerns regarding the Trust’s actions elsewhere in this report. However, regarding the specific matter of payment of the top-up fee, I am satisfied the Trust’s response to this as part of the complaints process was reasonable, appropriate and in line with relevant standards. I note the Trust has stated its willingness to assist the complainant and the care home to reach an agreeable solution to this matter. On foot of this final report, I would encourage the Trust to restate its offer to the complainant, and encourage the complainant to avail of this offer to reach resolution.

Injustice

141. The first Principle of Good Complaints Handling, ‘*getting it right*’, requires a public body to adhere to relevant policies and standards, including its own, and to take account of established good practice. In addition, the second Principle of Good Complaints Handling ‘*being customer focused*’, requires a public body to handle complainants promptly and sensitively, bearing in mind the complainant’s individual circumstances. I consider the Trust failed to adhere to these Principles in the manner in which it handled the complaints.

142. I consider these failures constitute maladministration. I am satisfied they caused the complainant to sustain the injustice of uncertainty and frustration, as well as the loss of opportunity to have his complaint handled in line with the Complaints Policy and DOH Guidance. Furthermore, it caused the complainant the time and effort of bringing this complaint to my Office.

143. I therefore uphold this issue of complaint.

CONCLUSION

144. I received a complaint about the Trust’s investigation into the theft the of resident’s wedding ring and its handling of the complainant’s concern regarding a separate incident. I also received a complaint about the Trust’s complaints handling.

145. The investigation established the Trust failed to fully adhere to the Safeguarding Procedures and Joint Protocol regarding its investigation into the theft of the resident’s wedding ring. It also established the Trust failed to keep sufficient records to demonstrate its adherence to the Safeguarding Policy and the Safeguarding Procedures regarding the separate incident the complainant reported. In addition, it established the Trust failed to handle the complainant’s complaints in line with relevant standards.

146. These failures constitute maladministration. They caused the complainant and the resident to sustain the injustice of uncertainty, frustration and loss of

opportunity. They also caused the complainant to have to take the time and effort to bring this complaint to my Office.

147. I therefore upheld each issue of complaint.

Recommendations

148. I recommend that the Trust provides the complainant with a written apology in accordance with NIPSO ‘Guidance on issuing an apology’ (June 2019), for the injustices caused as a result of the failures identified within **one month** of the date of the final report.

149. I also recommend the Trust provides the complainant with a copy of its CCTV policy within **one month** of the date of the final report. If no such policy exists, I recommend the Trust confirms this with this complainant within this timeframe.

150. I further recommend, for service improvement and to prevent future reoccurrence, that the Trust:

I. brings the contents of this report, and the learnings identified in it, to the attention of the DAPO and the senior social worker who addressed the complainant’s separate concern, and discusses this learning with those individuals as part of their next performance appraisal;

II. provides refresher training to relevant staff regarding the Safeguarding Policy, the Safeguarding Procedure, and the Joint Protocol;

III. brings the contents of this report, and the learnings identified in it regarding complaint handling, to the attention of all staff involved in handling the complaints so they can reflect on the findings set out; and

IV. implements an action plan to incorporate these recommendations and 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 relevant policies)

151. Finally, I wish to pass on my condolences to the complainant and his family, on the death of his mother.

Margaret Kelly
Ombudsman
24 July 2023

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and 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.

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

- Acting in accordance with the law and relevant guidance, and with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure, in the right way and at the right time.

Being customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.

- Providing honest, evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants.

Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.