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

Report Reference: 202003022

The Northern Ireland Public Services Ombudsman
33 Wellington Place
BELFAST
BT1 6HN
Tel: 028 9023 3821
Email: nipso@nipso.org.uk
Web: www.nipso.org.uk
@NIPSO_Comms

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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SUMMARY

I received a complaint about the actions of the Western Health and Social Care Trust (the Trust). The complaint related to the process the Trust followed when it received a complaint about care provided to the complainant's mother (the Resident) when she resided in a Care Home. It also concerned how the Trust managed the related Serious Adverse Incident (SAI) process.

I found the Trust's investigation of the complaint was flawed and lacked empathy. The level of basic inaccuracies on matters of record caused me great concern. This included challenging the complainant that she did not raise the issue of bruising on her mother until after her death when written evidence clearly demonstrated this was not the case. This and other clear inaccuracies both called into question the quality of the Trust's investigation process and their empathy for someone who had just lost their mother.

Further the Trust failed to take several opportunities provided by the complainant to resolve this matter and instead lead her to believe that it would re-open her complaint only to advise her eight months later that it considered the matter closed and gave the complainant the time, trouble and distress of bringing the complaint to my office.

The complainant specifically asked and was assured by the Trust that the SAI investigation would consider if appropriate clinical observations were undertaken after her mother had experienced a choking episode. However, the Trust both failed to make a note of this and failed to communicate it to the SAI team. When the SAI issued its first report, a year after the complainant's request, this issue was not considered, and the SAI team had to reopen and update the report. The updated report still failed to make any finding on this issue and has not as yet been submitted to the Department of Health. This was both a failure to act in accordance with the

SAI procedure and maladministration as well as causing the complainant significant distress.

I recommended that the Trust apologise to the complainant for the failures identified. I also recommended that the Trust review its complaints and SAI investigation processes and make appropriate revisions following its reconsideration. Furthermore, I recommended action for the Trust to take to prevent the failures recurring.

THE COMPLAINT

1. This complaint was about the actions of the Western Health and Social Care Trust (the Trust). The complainant raised concerns about the Trust's consideration of her complaint. It was also about the Trust's handling of the subsequent Serious Adverse Incident[1] (SAI) investigation process.

Background

2. On 24 February 2022 the complainant raised concerns to the Trust about care and treatment her mother (the Resident) received while residing in one of its care homes. Sadly, her mother passed away in the home in October 2021.

3. The Trust issued its response to the complaint on 5 July 2022. In its response, the Trust advised the complainant it would initiate an SAI investigation.

4. On 20 July 2022 the complainant contacted the Trust to seek clarification on its response. She contacted the Trust again on 27 July 2022 to ask if its letter issued on 5 July 2022 was its '*full and final response'*. The Trust informed the complainant by email on 27 July 2022 that it was not its final response.

5. Further to this correspondence, the Trust offered the complainant a meeting regarding her complaint. While the complainant initially agreed to meet with the Trust in November 2022, she cancelled the meeting and advised she would provide a further response in writing.

6. The complainant wrote to the Trust on 5 December 2022. On 3 January 2023, the complainant informed the Trust she would refer her complaint to my office. However, the complainant wrote to the Trust on 16 January 2023 to provide additional documentation and raise concerns about the investigation into her complaint. Following receipt, the Trust contacted my office and explained it considered its internal complaints process exhausted, but it was considering whether to reopen the complaint. It was advised this office would not proceed if the Trust was still engaged with the complainant.

[1] An SAI is defined as any event or circumstance that led or could have led to unintended or unexpected harm, loss or damage.

7. The complainant spoke to the Trust on 23 February 2023 and advised she would now refer her complaint to my office. The Trust shared its provisional findings of its SAI investigation with the complainant at a meeting on 24 February 2023.

8. On 7 March 2023, the complainant advised the Trust she would not refer to my office and instead asked the Trust to respond to her concerns about its investigation into her complaint. The Trust again contacted my office. It was advised to decide on how it wished to proceed with the process. The Trust wrote to the complainant on 28 March 2023 and advised it decided not to re-open her complaint.

9. I enclose a chronology outlining the Trust's complaints process at Appendix three to this report.

Issues of complaint

10. I accepted the following issues of complaint for investigation:

Whether the Trust's handling of the complaint was appropriate and reasonable.

Whether the Trust managed the SAI Investigation process appropriately and in accordance with relevant guidelines.

INVESTIGATION METHODOLOGY

11. 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 and SAI processes.

Relevant Standards and Guidance

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

The general standards are the Ombudsman's Principles:

- The Principles of Good Administration
- The Principles of Good Complaint Handling

13. 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 of those individuals whose actions are the subject of this complaint.

    The specific standards and guidance relevant to this complaint are:-

    - The Western Health and Social Care Trust's Policy and Procedure for Management of Complaints and Compliments/Service User Feedback (the Trust's Guidance).
    - The Health and Social Care Board's Procedure for Reporting and Follow up of Serious Adverse Incidents November 2016 (SAI Procedures); and
    - The Department of Health's Guidance in relation to the Health and Social Care Complaints Procedure, April 2019 (the Complaints Procedure).

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

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

15. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. I carefully considered all of the comments I received.

THE INVESTIGATION

Issue 1: Whether the Trust's handling of the complaint was appropriate and reasonable.

Detail of the complaint

16. The complainant said there were inaccuracies within the Trust's response about her concerns around:-
    - The unexplained bruising on the Resident's body.
    - The Resident's ability to feed herself and why she was not brought to the dining room.

17. The complainant said the Trust did not acknowledge her concerns when she raised them. Instead, it decided to close the complaint.

Evidence Considered

18. I considered the following guidance:
    - The Trust's guidance; and
    - The Complaints Procedure

The Trust's response to investigation enquiries

19. The Trust provided a timeline of the complaints process, as outlined in the Background section of this report.

20. The Trust stated it considered all relevant documentation and wrote to the complainant on 28 March 2023 to confirm it *'deemed the complaint exhausted and all information was provided that could be'*.

Relevant Trust Records

21. I enclose a chronology outlining correspondence between the Trust and the complainant at Appendix three to this report.

Analysis and Findings

22. I note the substantive issues the complainant raised to the Trust. However, my investigation focused on how the Trust handled the complaint. It did not consider the substantive issues the complainant raised.

The Trust's written response

23. The complainant was dissatisfied with the Trust's written response to her complaint issued on 5 July 2022. In particular, she said the Trust's response to two issues of complaint was inaccurate.

24. I firstly refer to the complainant's concern that the Trust's response stated she did not discuss the Resident's bruising '*with the social worker before your mother's passing. It was only at that point in time following your mother's passing that you felt it was something that needed to be explored further'.*

25. I note the records evidence the complainant emailed the Resident's social worker on 16 September 2021. In the email, the complainant referred to the bruising on the Resident's body. Based on this evidence, I am satisfied the complainant did, in fact, raise the matter of bruising with the social worker prior to her mum's passing in October 2021. Therefore, I consider the Trust's written response regarding this matter inaccurate.

26. I also refer to the complainant's concern that in its letter dated 5 July 2022, the Trust stated there was no record within the Care Home's pre-admission assessment, or subsequent documents, of the Resident's ability to recognise food following her transfer to the Care Home.

27. I reviewed the Care Home records. I note on 3 September 2021, the Care Home in which the Resident was then living, sent an email to the Resident's social worker. It stated *'she no longer recognises food, nor what to do and needs fed. She also at times has food in her mouth and is unsure of what this is so becomes upset and spits it out'*. The social worker forwarded this email to the Care Home's manager the same day.

28. The complainant provided this office with a document entitled *'This is me',*

which she prepared and gave to the Care Home Manager the day before the Resident's admission on 8 September 2021. The final paragraph of the document states, *'mum needs constant encouragement to drink enough fluids- she has said now that she 'doesn't know what to do' and this has also been said about food. These are two very recent developments/decline.'* Based on the evidence available, I am satisfied the Resident's Care Home records did refer to her difficulties with feeding.

29. Furthermore, the Trust stated in its response to the complaint that the Resident did not '*frequent the dining room or living areas of the Home'* as she isolated in her room for 14 days following her admission. This was to '*reduce the risk of covid transmission to other residents'*. However, I note the care home records did not evidence this period of self-isolation. On the contrary, notes and text messages between the complainant and her family evidence the Resident was in both the dining room and lounge during those 14 days.

30. These inaccuracies cause me great concern, more so because they are basic matters of record. I expect public bodies to manage complaints properly so that complainants can be confident they have dealt with their concerns appropriately. However, in this case, the Trust's failure to provide basic and accurate information within its response causes me to question the quality of its investigation. I consider that had the Trust fully considered the Care Home's records during its investigation of the complaint, these inaccuracies would not have occurred.

31. Criterion 4 of Standard 6 of the Complaints Procedure states '*responses will be clear, accurate, balanced, simple, fair and easy to understand. All the issues raised in the complaint will be addressed and, where appropriate, the response will contain an apology.'* It also requires bodies to '*address the concerns expressed by the complainant and show that each element has been fully and fairly investigated'*. For the reasons outlined, I do not consider the Trust acted in accordance with these elements of the guidance. I will consider the maladministration identified later in this report.

Local resolution

32. The complainant said the Trust closed her complaint instead of fully responding to her concerns. The Trust issued its response to the complaint on 5 July 2022. The Trust and complainant corresponded with each other regularly following this until the Trust ended the process in March 2023. I note the correspondence between these dates related to the Trust's SAI process and the involvement of my office.

33. The Trust's response to the complaint in July 2022 signposted the complainant to my office. This usually signifies the end of the complaints process. However, it is clear the complainant's correspondence up until March 2023 highlighted inaccuracies in the Trust's July response, and her request for it to clarify its response before she approached my office. I also note the Trust's correspondence with the complainant suggested it may re-open her complaint and consider the additional evidence she provided as rebuttal of its written response.

34. However, despite having an opportunity to consider the additional evidence the complainant provided, the Trust notified the complainant on 28 March 2023 that it considered the complaints process '*exhausted*'. It said this was because it did not have any additional information to share with the complainant. I cannot find any evidence to suggest the Trust considered the additional evidence the complainant provided.

35. Paragraph 3.45 of the Complaints Procedures 'Concluding Local Resolution' states, *'The HSC organisation should offer every opportunity to exhaust local resolution.'* I consider that in sending her additional evidence, the complainant presented the Trust with an opportunity to undertake further investigation and provide an accurate response to her complaint. I am disappointed it did not take advantage of this opportunity. In failing to do so, I consider the Trust did not act in accordance with the Complaints Procedure, as it did not take every opportunity to resolve the complaint at a local level.

36. The First Principle of Good Complaint Handling requires bodies to act in accordance with relevant guidance. The Second Principle of Good Complaint

Handling requires bodies to consider the complainant; to respond flexibly to the circumstances of the case and avoid unnecessary delays. The Fourth Principle of Good Complaint Handling requires bodies to ensure that complaints are investigated thoroughly and fairly to establish the facts of the case. I consider the Trust failed to act in accordance with these Principles in its handling of the complaint. I am satisfied this constitutes maladministration.

37. I uphold this issue of complaint. I have established that based on the evidence available, the Trust's response contained inaccuracies. The complainant provided the Trust an opportunity to re-examine her complaint. However, instead, it prolonged the process, allowing the complainant to believe it may re-open her complaint, only to end the process eight months after its initial response. I consider the failings identified caused the complainant to sustain the injustice of frustration, upset, and uncertainty. I am also satisfied that had the Trust handled the process appropriately, the complainant would not have had to take the time and trouble to bring her complaint to my office.

Issue 2: Whether the Trust managed the SAI Investigation process appropriately and in accordance with relevant guidelines.

Detail of Complaint

38. The complainant said the Trust's SAI process did not consider whether the Care Home carried out appropriate clinical observations of the Resident. She also said that despite meeting with the Trust on 24 February 2023 to discuss the SAI, it has yet to amend the report.

Evidence Considered

Legislation, Policies and Guidance

39. I considered the following guidance:
    - The SAI Procedure.

The Trust's response to investigation enquiries

40. The Trust stated the complainant raised the question of whether the Care Home took appropriate clinical observations of the Resident after her choking episode during their meeting in May 2022. However, the Trust did not communicate the complainant's question to the SAI team for investigation. When it realised its error, the SAI team revised its report in May 2023 and shared it with the complainant. It is yet to submit the revised report to SPPG[3]. It said it did not do so because of my office's investigation and the family's decision not to engage.

41. The Trust stated it did not retain a file containing notes of internal meetings conducted as part of the SAI investigation. This was because the meetings took place by telephone call and it did not retain a written record. It noted the '*substance*' of discussions of the SAI investigation with the complainant. It also did not formally record its meetings with the Care Home's management team.

Relevant Trust Records

42. The records document that the Trust competed its SAI report and submitted it to the SPPG in January 2023.

43. The records also contain a revised SAI report. It is not signed or dated.

44. I enclose a chronology outlining correspondence between the Trust and the complainant at Appendix three to this report.

Analysis and findings

45. The complainant raised concerns that the SAI investigation did not consider if the Care Home carried out appropriate clinical observations for the Resident following her choking episode.

46. The Trust's response to this office acknowledged the complainant raised the matter during their meeting on 13 May 2022 and provided an assurance to her that the investigation would consider this issue. It also acknowledged that it did

[3] SPPG- Strategic Performance and Planning Group (formerly Health and Social Care Board). It is responsible for planning, improving and overseeing the delivery of effective, high quality, safe health and social care services within available resources.

not communicate the complainant's request to the SAI review team. Therefore, the team did not investigate this issue or refer to it in its report. The Trust stated that after the complainant identified the error during their meeting in February 2023, it passed the request to the team. It then investigated the matter and shared an updated SAI report with the complainant on 16 May 2023.

47. I reviewed the revised report the Trust shared with my office. I note it is not signed or dated. I also note the report documented the Care Home notes from the time of the Resident's choking incident. However, I do not consider it makes any finding on whether the clinical observations taken were appropriate. While I appreciate that once the Trust realised its error it sought to rectify it, I am disappointed it failed to fully conclude the matter.

48. The introduction to the HSC leaflet '*What do I need to know about a Serious Adverse Incident'* states the purpose of a SAI is to is to find out what happened and why it happened. It is also to establish what can be done to prevent the failure happening again and to explain this to those involved. The matter of clinical observations for the Resident was '*hugely important'* to the complainant. The SAI was a means by which the Trust could address her concerns and provide her some element of reassurance. However, it failed to do so on both occasions.

49. I note, with concern, that the Trust stated it did not take any contemporaneous records during its SAI investigation, including its meetings with the complainant. Part 4.6 of the Procedure's Addendum states '*it is important that discussions with the service user / family are documented and should be shared with the individuals involved. Documenting the process is essential to ensure continuity and consistency in relation to the information that has been relayed to the service user / family'.* Therefore, in failing to do so, the Trust did not act in accordance with the SAI Procedure. I also cannot discount the link between this and the failure to communicate the complainant's request to the SAI team. I consider it likely that had the Trust taken appropriate records, it would have remembered to pass on the request.

50. The First Principle of Good Administration requires bodies to act in accordance with relevant guidance. The Third Principle of Good Administration 'Being open and accountable' requires bodies to keep proper and appropriate records and provide full, clear and evidence-based explanations for their decisions. I consider the Trust failed to act in accordance with these Principles in its handling of the SAI. I am satisfied that this constitutes maladministration.

51. Consequently, I am satisfied the maladministration identified caused the complainant to experience the injustice of frustration and uncertainty.

CONCLUSION

52. This investigation was about how the Trust handled a complaint. It found the Trust failed to provide an accurate response to two of the issues complained about. This called into question the quality of the Trust's investigation of the complaint. The investigation also found the Trust did not attempt to resolve the complaint at a local level.

53. The investigation was also about how the Trust carried out an SAI investigation. It identified the Trust's SAI report did not make a finding on the complainant's concern regarding clinical observations taken for the resident, which she specifically asked the team to investigate. It also found that the SAI team failed to retain adequate records during its investigation process.

54. For the reasons outlined above I uphold this complaint. I am satisfied the failures identified caused the complainant to experience the injustice of upset, uncertainty and frustration. I am also satisfied it caused the complainant the time and trouble of bringing her complaint to my office.

Recommendations

55. I recommend within **one month of the date of this report:**

    i. The Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (July

2019) for the injustice caused to her as a result of the maladministration identified.

56. I cannot ignore the flawed manner in which the Trust carried out its investigation and the lack of empathy shown to the complainant. I therefore recommend the Chief Executive conducts:

- a review of the oversight arrangements to ensure an appropriate standard of complaint investigations independent of service areas
- conducts an audit of its complaints process with a focus on the standard of investigation including, accuracy, timeliness, record keeping and communication with complainants
- Reviews a sample of oral and written responses to complaints to consider how well they demonstrate the principles of good complaint handling including responsiveness, openness and empathy.
- Develop from this a set of recommendations to improve complaints investigations and complaints handling.

It should provide this office with an action plan outlining its approach to this review within **three months** of the date of this report and the outcomes of this review within **six** months of the date of this report.

57. I further recommend the Trust provides training to relevant staff on effective complaint handling. This training should provide awareness to staff, using case studies if appropriate, of the impact an inaccurate complaints response has on complainants. The Trust should provide evidence that it has delivered this training within **three months** of the date of this report.

58. I also recommend that:

i. The Trust's Chief Executive reminds staff charged with the responsibility of investigating SAIs of the importance of:
   - Outlining in the SAI report their findings on the issues investigated, rather than simply presenting the evidence;
   - The importance of creating and retaining appropriate records during the SAI investigation process.

ii. I further recommend that within **six months** of the date of this report, the Trust should:

- Consider the information the complainant submitted between July 2022 and March 2023 as part of a further investigation of her complaint. Following its investigation, the Trust should review its initial response to the complaint and consider if it requires amendment.

- Consider the evidence relating to the Resident's clinical observations and make a finding based on that evidence. It should include this finding in its SAI report, share it with the complainant, and complete the process in accordance with the SAI Guidance.

59. It is clear the complainant fought very hard to seek answers from the Trust about her mother's care. I hope this report, and the recommendations made, help the complainant bring this painful process to a close. I wish to pass on my sincere condolences to the complainant for the loss of her mother.

MARGARET KELLY
Ombudsman **July 2024**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

Appendix 2

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, 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 learned from complaints.
- Including complaint management as an integral part of service design.
- Ensuring staff are equipped and empowered to act decisively to resolve complaints.
- Focusing 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.

2. 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 where appropriate co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

3. 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.

4. 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 and actions 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

5. 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.

6. 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 learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and the changes made to services, guidance or policy.