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

Report Reference: 202001626

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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
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Case Reference: 202001626

Listed Authority: The Western Health and Social Care Trust

SUMMARY

This complaint was about the care and support the Western Health and Social Care Trust (the Trust) provided to the complainant's son (the client) and his family over a period of 21 years from 2000 to 2021. The client has autism and learning disabilities.

Overall, I found that there were significant failings in care and treatment and, in particular, in the assessments and provision of services and support provided to the client over this extensive period. I was particularly concerned by the almost five-year gap in the provision of services and reviews when the client moved to the adult learning disability team.

The complainant raised several concerns. These included: -

1. the process associated with applications for a Disabled Facilities Grant, and the associated support from Occupational Therapy;
2. assessments carried out and the provision of Speech and Language Therapy and Positive Behavioural Support under Children's Services
3. management of the client's transition from Children's to Adult Services;
4. assessments carried out and the provision of Speech and Language Therapy, Positive Behavioural Support, Physiotherapy and Psychology Therapy under Adult Learning Disability Services;
5. lack of annual reviews under Adult Learning Disability Services; and
6. how the Trust addressed the complaint.

The investigation partially upheld Issue one and upheld Issues two to six of complaint.

The investigation identified the Trust failed to provide appropriate and reasonable care and support to the client and his family over a significant period of time. Specifically, the Trust failed to: -

- meet the full requirements of relevant legislation and policies in the Occupational Therapy assessments of 2014 and 2018. Specifically, in relation to these assessments: -
    - in 2014 and 2018 the Trust neither had specialist Occupational Therapists in place with autism expertise nor collaborated with autism experts in undertaking the assessment;
    - in 2014 the Trust did not consider the longer-term needs of the client and his family;
    - in 2014 and 2018 the Trust did not consider the client's wider sensory needs;
    - in 2014 the Trust did not consider the client's upcoming period of transition to adult services;
    - in 2014 and 2018 the Trust neither engaged with other relevant professionals nor considered other professionals' assessments; and
    - in 2018 the Trust did not consider the client's behavioural issues.
- consistently carry out appropriate and timely assessments;
- ensure the implementation of necessary actions to meet the client and his family's needs in both Children's and Adult Services;
- manage the client's transition from Children's to Adult Services appropriately; and
- undertake reviews during the first five years of the client's involvement with Adult Services.

The investigation also found the Trust failed to address all the complainant's concerns in its complaints process.

I recognise that the failures identified, and particularly over such a long period of time, caused the complainant and his family un-necessary anxiety, anger and frustration as well as depriving the client of appropriate assessments and service provision to enable him to progress as fully as possible and live independently.

Further, the lack of support to his family caused un-necessary stress in dealing with the client's behavioural issues, without the necessary and appropriate support.

I recommended the Trust provides the client and his family with an apology for the injustices caused by the failures. I made further recommendations for the Trust to address under an extensive evidence-supported action plan.

THE COMPLAINT

1. This complaint concerned the care and support the Western Health and Social care Trust (the Trust) provided to the complainant's son (the client) over a 21-year period. The complaint also included concerns about how the Trust responded to the complaint.

Background

2. The client was diagnosed with Autism in 2000, when he was three years old. The client has a learning disability and was diagnosed in 2011 with epilepsy. He also suffered from hypermobility and insomnia. The complainant believed the client's condition deteriorated because the Trust did not recognise or address either the client's complex needs or the challenges the family faced as they cared for him. The complainant believed the Trust's actions prevented the client from living as independently as possible in a safe and private space close to his family.

Issues of complaint

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

 Issue 1: Whether the Occupational Therapy assessments in relation to applications for Disability Facilities Grants between 2000 and 2021 met the relevant standards including the Best Practice & Criteria Guide for the Procedure of Housing Adaptations and made appropriate recommendations.

 Issue 2: Whether Children's Services carried out appropriate and timely assessments, particularly in relation to the provision and delivery of Speech and Language Therapy, and Positive Behavioural Support.

 Issue 3: Whether the Trust managed the transition from Children's to Adult services appropriately.

 Issue 4: Whether Adult Learning Disability Services carried out appropriate and timely assessments in relation to the provision and delivery of SLT, PBS, psychological and physical therapies.

Issue 5: Whether Adult Learning Disability Services performed appropriate reviews (annual and multidisciplinary).

Issue 6: Whether the Trust properly addressed the complainant's concerns through the Trust's complaint's process.

INVESTIGATION METHODOLOGY

4. To investigate this complaint, the Investigating Officer obtained all relevant documentation from the Trust, together with its comments on the issues the complainant raised. This documentation included information relating to the Trust's complaints process.

Independent Professional Advice Sought

5. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisors (IPA):

- A Social Worker (BA Psychology, Honours) (Certificate of Qualification in Social Work) (Diploma in Applied Social Studies) (Practice Teaching Award (Social Work)); with 40 years' experience in the Health and Social Care and third sector across a range of services, including long-standing experience in both Child Disability and Adult Learning Disability services and leading the development of transition to Adulthood polices and provision;
- An Occupational Therapist (PgDip) (BSc); with 25 years of clinical experience. This includes experience in assessment and advice related to minor and major Disabled Facilities Grants adaptations as a senior Occupational Therapist.

I enclose the Occupational Therapist's professional advice at Appendix four and the Social Worker's professional advice at Appendix five to this report.

6. I included the information and advice that informed the findings and conclusions within the body of this report. The IPAs provided 'advice'. However, how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

7. To investigate complaints, I must establish a clear understanding of the standards, both of general application and of 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[1]:
   - The Principles of Good Administration
   - The Principles of Good Complaints Handling

8. The specific standards and guidance referred to are those that applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

   The specific standards and guidance relevant to this complaint are:
   - The Mental Health Act (Northern Ireland), 1961 (MH Act);
   - The Mental Health Order (NI), 1986 (MH Order 1986);
   - The Health and Personal Services (Northern Ireland) Order, 1972 (HPS Order);
   - The Chronically Sick and Disabled Person Act, 1978 (Sick and Disabled Persons Act);
   - The Disabled Persons Act (Northern Ireland), 1989 (DisPA);
   - The Health and Personal Social Services (Northern Ireland) Order 1991, (Health and SS Order);
   - The Children's Order (Northern Ireland), 1995 (UNOCINI);
   - The Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order, 2003 (HSS Quality Order);
   - The Housing Order (NI), 2003 (Housing Order);
   - The Health and Social Care Reform Act (Northern Ireland), 2009 (HSC Reform Act);
   - The Autism Act (NI), 2011 (Autism Act);

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

- The College of Occupational Therapists' Code of Ethics and Professional Conduct for Occupational Therapists, 2001 (COT 2001);
- The College of Occupational Therapists' Code of Ethics and Professional Conduct for Occupational Therapists, 2005 (COT 2005);
- The College of Occupational Therapists' Professional Standards of Occupational Therapy Practice, 2007 (COT Standards 2007);
- The College of Occupational Therapists' - occupational therapy with people with learning disabilities, June 2009 (COT LD 2009);
- The Northern Ireland Community Occupational Therapy Managers Forum's Best Practice Criteria Guide for the Provision of Housing Adaptations, 2007 (HA Best Practice Guide);
- The Health and Care Professions Council's Regulating ethics and conduct at the Council for Professions Supplementary to Medicine, 2012 (HCPC Ethics);
- The Health and Care Professions Council's, Standards of proficiency: Occupational Therapists, 2013 (HCPC OT Standards);
- The Department for Communities and the Department of Health Adaptations Design Communications' Tool Kit, February 2014 (the Tool Kit);
- The Department of Health's Learning Disability Framework, 2015 (DoH LD Framework);
- The College of Occupational Therapy's Code of Ethics and Professional Standards and Professional Conduct, 2015 (COT 2015);
- The Royal College of Occupational Therapists' Adaptations Without Delay, 2017 (RCOT Adaptations Guide);
- The Royal College of Occupational Therapists' Professional Standards for Occupational Therapy Practice, Conduct and Ethics, 2021 (RCOT standards); and
- The Northern Ireland Social Care Council, Standards of Conduct and Practice for Social Workers, August 2019 (NISCC Social Work Standards).

9. The Occupational Therapist Independent Professional advisor (OT IPA) also referenced several additional guidance and strategies in her advice. These included:
   - The Department of Health's Learning Disability Service Framework Draft 2011-2012 (DoH LD Draft Framework);
   - The Western Health and Social Care Trust's Intensive Support (Learning Disabilities) Framework for Redesign of Community Support Services in Learning Disabilities, 2007 (Trust LD Framework);
   - The Department of Health's "People First": Community Care NI, 1990 (People First);
   - The Department of Health's Autism Strategy (2013-2020) and Action Plan (2013-2016) (DoH Autism Strategy AP 1);
   - The Health and Social Care Board's Northern Ireland Autism Adult Care Pathway, 2013 (HSCB Autism Pathway);
   - The National Autistic Society's Broken Promises, 2016 (NAS Report);
   - The Children and Young People's Strategic Partnership's Northern Ireland Children and Young People's Plan 2011-2014 (CYPSP Plan); and
   - The Department of Health's Autism Strategy (2013 – 2020) - Second Progress Report 2018 (DoH AP 2).
   - National Institute for Health and Care Excellence's Autism Quality Standards, 2014 (NICE Quality Standards); and
   - Department of Social Development/Department of Health's Inter-Departmental Review of Housing Adaptations Services: Final Report and Action Plan, 2016 (Housing Adaptations Action Plan).

10. The following additional guidance and research were referenced in the Social Worker Independent Professional Advisor's (SW IPA) advice:
    - Children and Young People's Strategic Partnership, Transition to Adulthood of Young People with Disabilities Draft Action Plan 2011 – 2014 (Transition Draft Action Plan);

- Northern Ireland Assembly, Research Matters' Learning Disability in Northern Ireland: Where are we now, August 2017 (NIA learning Disability Research);
- Northern Ireland Commissioner for Children and Young People, Review of Transitions to Adult Services for Young People with Learning Disabilities, September 2012 (NICCY Review);
- Health and Social Care Board, Autism Adult Care Pathway, Regional Autistic Spectrum Disorder Network, September 2013 (HSCB RASDN);
- The National Autistic Society Northern Ireland, Broken Promises, 2016 (Autism NI Report);
- Department of Health, Social Services and Public Safety 'Understanding the Needs of Children in Northern Ireland' (UNOCINI), June 2011 (UNOCINI Guidance);
- Autism Act (Northern Ireland), 2011 (Autism Act); and
- Department of Health Guidance in Relation to the Health and Social Care Complaints Procedure, April 2019 (DoH Complaints Guidance).

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

12. 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.

THE INVESTIGATION

Issue 1: Whether the Occupational Therapy assessments in relation to applications for Disability Facilities Grants between 2000 and 2021 met the relevant standards, including the Best Practice & Criteria Guide for the Procedure of Housing Adaptations and made appropriate recommendations

Detail of Complaint

13. This issue of complaint relates to the family seeking support from Occupational Therapy (OT) in its role of assessment of needs and recommendations for adaptations as part of the process of application for a Disability Facilities Grant (DFG). There were four OT assessments undertaken in relation to this process. These were in 2002, 2014, 2018 and 2021. The complainant said the first three OT assessments did not result in recommendations for adaptations which met the client's needs. The complainant said the fourth assessment yielded a positive outcome in recommendations for adaptation, although this was not fully implemented. The complainant said the assessment process for these applications was not appropriate and did not take account of the client's complex needs. Further, the complainant said the impact of the Trust's lack of long-term planning for the client's right to live independently has had a '*harmful'* effect on the client, particularly his mental health.

Evidence Considered

Legislation/Policies/Guidance

14. I considered the following:
    - The Sick and Disabled Persons Act;
    - The DisPA;
    - UNOCINI;
    - The Housing Order;
    - The Trust LD Framework;
    - The HSC Reform Act;
    - The Autism Act;
    - The CYPSP Plan;
    - The DoH Autism Strategy AP 1 and AP 2;
    - HSCB Autism Pathway;
    - NICE Quality Standards;
    - The DoH LD Framework;
    - Housing Adaptations Action Plan;
    - NAS Report;

- The HCPC Ethics;
- The HCPC OT Standards;
- The RCOT Adaptations Guide;
- People First;
- HA Best Practice Guide;
- The Tool Kit;
- The RCOT standards; and
- COT LD 2009.

Key extracts from the relevant policies and guidance are included either within the OT IPA's advice at Appendix four or at Appendix six, as appropriate.

Trust's response to investigation enquiries

15. As part of investigation enquiries, the Trust had an opportunity to respond to the complaint. The Trust's response to my enquiries for all six issues of complaint is at Appendix three to this report.

Relevant records

16. I considered the Trust OT records for the period of 2000 to 2021. These included referrals to the OT Department and records associated with each of the OT assessments carried out under the DFG process.

Relevant Independent Professional Advice

OT IPA advice

17. The OT IPA provided detailed advice about the assessments OTs undertook in relation to potential adaptations under the DFG process in 2002, 2014, 2018 and 2021. The OT IPA provided advice related to: -
    - the DFG application and decisions process and the OTs' responsibilities in this process;
    - the compliance of the OTs' assessments with relevant legislation and guidance;
    - the OTs' inclusion of other professionals' input to their assessments;

- the appropriateness of the OTs' relevant experience;
- the OTs' consideration of the client's wellbeing; safety; sensory and occupational needs; and personal choice in their assessments, as well as safeguarding of the client's siblings;
- communication of the rationale for the OTs' assessments outcomes to the client and his family;
- the requirement for a specialist OT to be involved in the assessments;
- the outcomes of the OTs' assessments in relation to the client and his family's needs;
- consideration of the client's longer-term needs in the OTs' assessments; and
- record-keeping.

The OT IPA's complete advice is at Appendix four.

Responses to the Draft Investigation Report

18. The complainant and the Trust were given an opportunity to provide comments on the Draft Investigation Report. Where considered appropriate, comments are either reflected in changes to the report or are outlined in paragraphs 19 to 23 and 82 to 83.

Trust response

19. The Trust OT Department stated, in 2001, the Community OT (COT) recommended ground floor showering facilities and outdoor fencing at the complainant's previous address. Further, in 2014 and 2018, the COTs completed assessments at the client's present address but no made no recommendations. The Trust OT Department stated the OT assessments are undertaken in line with regional guidance.

20. The Trust stated, when the COT assessed the client's needs in 2018, the family's expectations were for '*an independent living unit attached to the family home'*. The Trust stated, '*this is beyond the remit of [an] OT and the underpinning legislation relating to what a DFG will fund under the Housing*

Order'. The Trust also stated, however, in 2021, the Adult Learning Disability OT Service's (ALD OT) assessment recommended a ground floor bedroom, ensuite bathroom and a separate regulation space. The Trust stated the ALD OT recommended these because of '*a change in family circumstance and a deterioration in the [client's] presentation'.* The Trust stated it did not have an ALD OT in place until April 2021. It stated this service provides '*a specialist level of assessment in relation to the impact of a learning disability and ASD on function*'. The Trust refuted the complainant's statement that recommendations it made in 2021 were not fully implemented. The Trust stated OTs completed their role in the DFG process and later stages of the DFG applications process lie outside the Trust's remit. Further, the Trust stated it met with the complainant on 7 November 2022, at which meeting *'the complainant acknowledged he was satisfied with the OT recommendations'* and his outstanding issues related to the processes outside the Trust. The Trust stated the ALD OT has experience in both sensory integration and housing adaptations. Therefore, this OT was '*best placed to complete assessments and make the recommendations'*. The Trust acknowledged this expertise was not available prior to 2021 due to difficulties in recruitment.

21. The Trust referenced the OT IPA's advice related to the Trust's consideration of *'non-physical issues and sensory needs'*. The Trust disputed the OT IPA's view and stated the COT considered these needs '*when they impacted'* on the client's access to essential facilities within the home. The Trust stated, '*this did not always lead to an adaptation if an internal solution was possible'.*

22. The Trust referenced the range of legislation, guidance, strategies and policies which the OT IPA cited in her advice. The Trust stated the OT IPA did not understand *'the implementation of primary legislation'* related to housing adaptations in Northern Ireland. The Trust further stated, although '*the Trust has working knowledge of [these additional documents], these do not supersede the primary legislation'.*

23. The Trust accepted the findings and recommendations related to Issues two to six.

Legal Advice

24. In consideration of the Trust's response to the OT IPA's advice, I sought legal advice. Specifically, this advice related to the Trust's responsibilities in relation to legislation, policies and guidance other than the Chronically Sick and Disabled Person Act, 1978 when conducting assessments for housing adaptions. The legal advice also encompassed whether there were any aspects of additional legislation, policies or guidance which would either conflict with the Trust's responsibilities under the Act or could result in the additional requirements overriding the base legislation.

Analysis and Findings

2002 OT Assessment

25. There were significant gaps in the records the Trust provided related to the OT assessment of 2002. The Trust stated this was because it had disposed of these records in line with its records management policy schedule. The absence of these records impacted on the investigation for this element, particularly in relation to the OT IPA's provision of advice. This is because there was no substantive evidence base on which a conclusive determination could be made.

26. I note the OT IPA advised that the COT department discussed the client at a Multi-Disciplinary Team Meeting (MDT) which indicated the COT sought additional information for the assessment from other professionals, and which was appropriate. She advised that the MDT included a paediatrician, clinical psychologist, educational psychologist, social worker, teacher and speech and language therapist and which *'should have been sufficient to flag potential sensory issues or typical reactions and behaviours of children with Autism and Learning needs'.* The OT IPA referenced the COT 2001 and advised, *'in discussing the case with multiple other professionals, who knew the patient and/or knew about Autism, the COTs complied with standards of proficiency'.*

27. The OT IPA advised that, in 2001 and 2002, the HA Best Practice Guide and the Tool Kit were not yet published. She advised, therefore, the COT should *'have worked to expected practice within the original legislation which was to*

ensure eligibility for assessment and assess needs'. Further, at this time, *'this would already have included behavioural issues which impact on the patient's access to essential facilities in the home and his safety.'* I note the OT IPA advised, in this period, COTs would *'have primarily worked with clients who had physical disabilities. Autism is not primarily a physical disability so would not necessarily have been a key area of expertise for COTs at that time … It is now known that many apparent "behaviours" are in fact responses to sensory issues, this was not common knowledge even among COTs or psychologists at the time of the assessment'.* She also advised that *'a detailed sensory analysis would not have been usual or expected in 2002'.* Therefore, it was reasonable, at that time, for sensory issues not to be considered *'beyond the general impact of the house environment'.*

28. I note the OT IPA advised the COT's decision to not recommend an extension because it was not the optimum solution was consistent with the COT 2001.

29. I note the OT IPA's advice there was evidence the COTs considered the family's needs; for example, the COT suggested soundproofing the existing bedrooms. She referenced the COT standards. She further advised, as the assessment resulted in recommendations for changes to a downstairs bathroom, which was not part of the original referral request, *'it is reasonable to assume [the] COT looked more broadly and included other occupational needs within the assessment'.* The OT IPA also advised that the COT considered and addressed the client's need to play outside as a fence was recommended.

30. I note the OT IPA's advice, '*the records for the 2002 case are incomplete with the key report missing; therefore, there is no evidence on which to examine the appropriateness of the COT's decision making'.*

31. I accept the OT IPA's advice and am satisfied that, in the context of the period, the COT's consideration of the client's autism, the wider family's needs and consultation with other professionals were appropriate. However, I refer to the OT IPA's advice about the absence of all relevant records; therefore, I am unable to determine whether the COT's decisions in this assessment were appropriate.

2014 OT assessment

32. The OT IPA advised, in 2014, the COT's role continued to be assessment for recommendations of '*equipment or adaptations which were "necessary and appropriate", taking into account long-term needs of the client and the needs and abilities of carers'.* She referenced the Autism Act and advised, *'assessment should have changed to reflect an increased awareness'* of this. Specifically, that the Autism Act *'clearly established Autism as a long-term disability and took some focus away from purely physical needs and highlighted the ongoing nature of needs within Autism and also learning disabilities'.* She referenced the Trust's statement the Autism Act could not *"supersede"* the Sick and Disabled Persons Act. I note the OT IPA advised, the Sick and Disabled Persons Act does *'not conflict with the Autism legislation and related policy requirements but should be complementary and are certainly not mutually exclusive'.*

33. Further, the OT IPA referenced the Took Kit. She advised that COTs have an '*obligation to seek further "medical, social or psychological information in order to form a longer-term picture of housing needs".* The OT IPA referenced the HA Best Practice Guide which recommended a senior OT should conduct assessments like the proposed extension. She advised, by this point, a senior COT should have been aware of both the '*impact of environment on the behaviour of people with autism*' and contemporary thinking about *'autism-centred design'.* I note her advice, health and social care bodies in Northern Ireland, including COT departments, would be expected to '*develop and implement strategies*' to comply with the Autism Act. Further, where a senior OT assessing for such a proposal did not have the necessary autism understanding, it would be expected they would collaborate jointly with other expert professionals in an assessment; consider fully any impact on carers; and plan for the client's future expected needs.

34. The OT IPA referenced the requirements of the HSC Reform Act. She advised, although '*COT assessments for adaptations were not specified within the Act, these would be contained within the obligation to commission services to meet health and social care needs'.* The OT IPA also referenced

the DoH Autism Strategy AP 1 and AP 2. She advised these strategies represented the DoH multidisciplinary and multi-agency response to the increased understanding that those with autism faced difficulties with '*transition to adult services'.* I note the OT IPA's advice these strategies *'should have informed any COT assessments for adaptations and associated decisions'.* The OT IPA also referenced the UNOCINI the Trust completed in 2014, which detailed the client's family's needs. She advised there is no evidence the COT considered this in the assessment. The OT IPA advised this conflicts with the Trust's requirements to consider the needs of carers under the Autism Act. Further, the Autism Act required the Trust to ensure '*all existing policies, practices and procedures'* met the legislative requirement, including that behavioural needs were as significant as physical needs in applying for assistance. The OT IPA advised, *'this should have applied to decision making within the COT assessment for adaptations process'.*

35. The OT IPA referenced the NICE Quality Standards. She advised these '*stipulated that Autism should not be treated medically*'. Consequently, this placed an *'emphasis [on] … social care and the management of issues arising from the client's autism'.* I note her advice that this included consideration of support for both the client and their family and their *'long-term well-being*'. The OT IPA referenced the Northern Ireland Executive's discretion about application of NICE Guidance. However, she also advised the NICE Quality Standards are cited within the HSCB Autism Pathway *'as a key strategic driver'*. The OT IPA further advised that the Trust '*is recorded as a stakeholder'* in the HSCB Autism Pathway. The OT IPA highlighted the requirements of the NICE Quality Standards related to ensuring there is staff capacity and capability to appropriately assess those with autism, including environmental factors. The OT IPA advised that the Trust, therefore, *'had an obligation to ensure that the causes of the difficulties leading to the referral for a COT assessment for adaptations were investigated. The assessing COT would therefore take a lead in considering the behaviours which led to the referral and find negotiated solutions with the family and other carers'.*

36. The OT IPA provided advice about the requirements to consider the client's long-term needs as he headed to transition to adult services. She advised, although in 2014 the client was not yet 18, the COT should have given *'some consideration of any changes in care needs arising from their transition to adulthood'.* I note her advice, whilst this may not have led to recommendations for an extension, the COT should have considered these needs.

37. The OT IPA referenced the Tool Kit and the HA Best Practice Guide. She detailed how the COT's assessment of 2014 met the Tool Kit's requirements. However, I note her advice that the format of the Tool Kit '*remained more appropriate to physical … than behavioural issues*'. Further, the OT IPA advised that there were limitations to the HA Best Practice Guide in relation to consideration of additional guidance and legislation because it did not *'sufficiently cover behaviour or carer needs'.* The OT IPA also advised, however, the HA Best Practice Guide stipulates that adaptation plans "*must take into … consideration … long-term requirements when appropriate*." She advised, because the client was approaching transition to adult services, it would have been appropriate for the COT to consider future planning. The OT IPA advised that the COT's assessment was '*centred only on certain current needs'* at that time with *'no consideration … given to changes in circumstance'* related to either the client leaving full-time education or '*changes in the carers' abilities to meet any changes in need'.*

38. The OT IPA also advised the assessment was limited because it did not consider the client's sensory needs. I note her advice, as all those with Autism '*have sensory differences, it would have been reasonable and good practice to include sensory information into any holistic assessment of home-based needs'.* However, there was no evidence the COT discussed this during assessment. The OT IPA advised this was of particular significance in relation to the client's interaction with his sister. She advised, in addition to the COT's omission of consideration of the UNOCINI and the Paediatric OT's input, the COT did not discuss the concerns about the client's impact on his younger sister with the client's parents. The OT IPA referenced the records of the COT's *'explanation to [the client's] parents'* about her remit and advised this

'narrows the scope of potential discussions'. This is because, if the client's family was not aware that '*sensory and behavioural needs were valid topics for discussion they may not have shared all relevant information'* and there is no evidence the COT included the UNOCINI in the assessment, where this issue was documented.

39. The OT IPA provided advice about the COT's consideration and consultation with other relevant professionals in assessing the client's needs. She advised that it would be reasonable, and in line with good practice, for the COT to ask the client's parents about other professionals involved when discussing the referral with them. I note her advice, there is no evidence of this within the assessment. The OT IPA advised this was of particular significance in relation to the client's future needs, which should have been considered. Further, there is no evidence the COT sought information about the client's transition needs and it is not addressed in the assessment. The OT IPA advised that the COT did not consider the client's longer-term needs, although this would be considered as good practice. She concluded that relevant good practice required *'joint working, consideration of the needs of the carer and future planning, particularly around transition times but none of these are evident in the COT assessment'.*

40. I note the OT IPA's advice the COT assessment appropriately changed focus in response to the family's request to consider the needs of the client's older sister. Further, she advised that, although the COT did not detail the client's younger sister's safety and wellbeing in the assessment, therefore, it is unclear if the COT considered her needs, the COT's suggestion the client move downstairs would have helped protect his younger sister. The OT IPA advised that the client's parents declined this. The OT IPA concluded that the COT considered the client's physical and occupational needs contemporaneous with the assessment but did not consider upcoming longer-term needs in line with good practice and relevant legislation and guidance. Further, that whilst the COT considered behavioural issues in relation to adaptation, this was only to *'a limited extent'.*

41. I note the OT IPA's advice there is no evidence of the client being *'aggressive'* in the assessment.

42. The OT IPA referenced the Trust LD Framework. She advised that this document, developed in 2007 by a multi-agency group, outlined the agreed approach to re-modelling services for people with Learning Disabilities. Further, it acknowledged there was no specialist OT in post at that time but also '*stated clearly'* the need for multi-disciplinary assessments, with OTs essential to the plan. I note the OT IPA's advice that, from 2007, *'it would have been reasonable to expect the Trust would have initiated recruitment of specialist OT within the Learning Disabilities team'.* Further, as the Trust Community Services Manager participated in this discussion, '*it would also have been reasonable to expect changes within the Community COT team to reflect the change in priorities to maintain home based care for clients with complex learning needs*'. She advised, the expected result would have been either greater expertise about autism in the COT team or increased joint working with other relevant specialists.

43. The OT IPA referenced the DoH Autism Strategy AP 1, AP 2, the Autism Act and the HSCB Autism Pathway. She advised, in the circumstances that the Trust did not recruit a specialist OT in response to the Trust LD Framework, it would be reasonable that the Trust did so in response to these in the period of 2008 to 2013. In relation to the HSCB Autism Pathway, I note the OT IPA's advice that this included the need to consider sensory processing strategies in environmental adaptations. She advised that this document cites OTs as professionals who should contribute to the MDT. The OT IPA concluded, by 2013, prior to the second OT assessment, the Trust should have recruited a specialist OT. She further advised, if difficulties presented in recruitment, in line with good practice as required by OT professional standards and the Autism Act, the Trust should have ensured the COT worked in collaboration with relevant experts available in Northern Ireland.

44. The OT IPA referenced the Trust's statements in response to the Draft Report related to the Sick and Disabled Persons Act as being the only structure under

which COTs operated. She also referenced the Trust's dismissal of other legislation and policies as *'subordinate*'. She advised, whilst the Sick and Disabled Persons Act provides COTs with authority in this role, *'as is common throughout legislative and regulatory frameworks, other legislation… interacts with it'.* The OT IPA advised, by 2014, 'i*t was incumbent on Trusts in Northern Ireland to act in accordance'* with relevant legislation and that this included COTS '*in discharge of their duties around adaptation assessments'.* I note the OT IPA's advice that, *'there was no additional significant legislation introduced'* between 2014 to 2021. However, the assessment in 2021, which a specialist OT carried out in the role of a COT, *'was a significantly more holistic assessment … which considered all the aspects advocated by the legislation and guidance … which the Trust dismissed as not relevant to the statutory duties of OTs in assessing housing adaptations (prior to 2021)'.* The OT IPA concluded that the Trust undertook the assessment in 2021 under the statutory parameters and duties of the Sick and Disabled Persons Act; therefore, the requirements in 2021 reflected those in 2014.

45. The OT IPA advised that it cannot be determined whether the COT assessments from 2014 onwards would have led to different outcomes if the COTs had considered all the necessary and appropriate factors in the assessments and had ensured specialist input. I note her advice, however, if these requirements had been implemented, it would provide assurance over the assessment outcomes.

46. I refer to the legal advice provided. I am satisfied there is no conflict between the requirements of the Sick and Disabled Persons Act and the other legislation, policies and guidance the OT IPA referenced. Further, I am satisfied it is reasonable to expect that the Trust should implement relevant legislation, polices, strategies and guidance to satisfy its duty to the client and his family. This includes that which is not specific and unique to Northern Ireland but represent responsibilities in public law and good practice which are applicable throughout the United Kingdom. Therefore, I am satisfied the OT IPA's advice on the applicability and implementation of the additional requirements is legally sound.

47. I accept the OT IPA’s advice and am satisfied that, at the time of the COT assessment in 2014, there was significant relevant legislation, guidance, polices and strategies in place with which the Trust was required to comply. These applied to COTs in undertaking assessments for adaptations. These included the need to: - either have specialist OTs in place or COTs to engage in joint working with relevant autism experts; consider the longer-term needs of the client and his family in the COT assessments; and consider the client’s wider sensory needs. I accept the OT IPA’s advice and am satisfied there is no evidence that the COTs and the Trust met these requirements. Further, I accept the OT IPA’s advice and am satisfied the COT assessment should have considered the client’s upcoming period of transition to adult services, engaged with other professionals and considered other professionals’ assessments, including the UNOCINI; however, there was no evidence the COT did so. I consider this to be a failure in care and support of the client and his parents.

48. I also accept the OT IPA’s advice and am satisfied the COT’s 2014 assessment met relevant standards in relation to records and how the COT negotiated outcomes with the client’s family. Further, although the COT only partially considered the needs of the client’s siblings in the assessment, the proposed solution of moving the client downstairs and sound-proofing the upper bedrooms would have addressed his siblings’ needs at that time. However, the family declined this suggestion.

49. I refer to paragraphs 46 to 48 above. Therefore, I partially uphold this element of the complaint.

2018 OT assessment

50. The OT IPA advised the COT’s 2018 assessment references that the client was distressed and agitated; however, the records indicate the COT then left the client in his bedroom with no other details about this incident documented. I note her advice, although the COT assessment activities would have been ‘unusual’ for the client and therefore may have caused distress, she could not determine this.

51. The OT IPA referenced the Housing Adaptations Action Plan. I note her advice, in assessing the client's function and ability to safely access essential activities and promote independence with essential activities, the COT did not consider the "*needs of people with sensory, hidden, learning and mental health issues"* as recommended.

52. The OT IPA advised, by 2017, good practice in OT departments included routine assessment for the needs of those with autism. Further, she advised, because there is no evidence the COT considered the factors noted in the previous paragraph as required, the COT did not demonstrate they had this required expertise. I note the OT IPA's advice, in this case, the COT should then have sought the input of an appropriate expert in line with good practice; however, there is no evidence the COT did so, and this was not reasonable. The OT IPA reiterated her advice related to the assessment of 2014. She advised that the Trust had specific obligations related to support of clients with autism, and which by 2017 '*should have been embedded in all areas of the Trust'.* The OT IPA referenced the Trust's statements that it regretted there was no ALD OT in place by 2017*. S*he advised, therefore, the Trust recognizes, that by the time of the COT assessment in 2018, this service was a requirement including the associated expertise and input. The OT IPA advised, although *'acknowledging the Trust's difficulties in maintaining a specialist ALD OT, by this point, it was incumbent on the Trust to meet the requirements of the range of legislation and strategies for autism'* in Northern Ireland.

53. The OT IPA referenced the HSCB Autism Pathway and the NAS Report. She advised, by 2017, it would be reasonable and in line with good practice to expect the Trust to have implemented the HSCB Autism Pathway. The OT IPA advised that this recommended assessment of triggers to behaviour which challenged, including environmental factors. I note her advice, COTs are *'environment experts*'. Therefore, COTs would have a lead responsibility in this requirement. Consequently, COTs needed either autism expertise or to establish close working relationships with experts in sensory and behavioural issues. She concluded that, if the COT department did not have the necessary expertise, it would be reasonable and good practice to expect the

Trust to source appropriate expert input from elsewhere.

54. I note the OT IPA also reiterated her previous advice about the Trust and COTs' obligations to incorporate relevant legislation and policies into the COT assessments beyond the Sick and Disabled Persons Act.

55. I note the OT IPA's advice the Trust had an obligation to support the client, carers and family's wellbeing. Therefore, the COT should have discussed the outcome of the assessment with the referrer. This is because the assessment did not result in adaptation recommendations, following which, the referrer could continue to identify appropriate support for the family, who appeared to be approaching a crisis point.

56. The OT IPA advised, in the COT's 2018 assessment, there is no evidence the COT considered the necessary factors specific to those with autism and learning disabilities. Therefore, the COT did not *'thoroughly assess'* the client's needs. Further, the OT IPA advised there was no evidence the COT, who was not an autism or learning disabilities specialist, sought appropriate expert support or advice in line with requirements in place at that time. I note the OT IPA's advice there were several other required actions which the COT did not do. These included that the COT should have liaised with the referrer to clarify the original concerns which led to the referral; gathered information from, or consulted with, other involved professionals; considered the environmental sensory issues related to the client's distressed behaviour; and ensured solutions considered future needs. The OT IPA referenced both a sensory assessment and the involvement of a specialist OT with the client in 2016/17. These related to another department or agency. However, the OT IPA advised it is clear the COT did not involve the specialist OT or consider the sensory assessment in their assessment. The OT IPA advised that the sensory assessment would have been relevant. This is because the assessment describes the sensory regulation activities as necessary several times each day. She advised that this information could have supported the need for additional space.

57. I also refer to paragraph 45 above related to the lack of assurance over the COT's assessments outcomes of 2014 and 2018 because of the omission of relevant factors and specialist input in the assessments.

58. I refer to my finding at paragraph 46 related to the legitimacy of additional legislation, guidance and strategies the OT IPA referenced. I also accept the OT IPA's advice and am satisfied, because the COT did not fully consider the client's behavioural and sensory issues in the assessment, the COT's 2018 assessment did not constitute a thorough assessment. I accept the OT IPA's advice and am satisfied that the Trust should have had a specialist OT in place at this point or should at least have sought appropriate expert input but did not do so. Further, I accept the OT IPA's advice and am satisfied the COT should have considered other professionals' input, including the sensory assessment but did not do so. I accept the OT IPA's advice the COT's and Trust's omissions were not reasonable and not in accordance with relevant legislation, guidance and good practice. I consider these constitute failures in care and support. Therefore, I uphold this element of the complaint.

2021 OT assessment

59. The OT IPA advised that the OT assessment of 2021 was '*thorough and holistic … considered a range of … [and] demonstrated an understanding of a range of needs*'. I note her advice, this assessment considered the client and his family's longer-term needs, including his need for independence. The OT IPA advised that a specialist OT from the Adult Learning Disabilities Team (ALD OT) carried out this assessment. Further, the ALD OT identified necessary actions which the ALD OT followed through in recommendations for adaptations. The OT IPA advised this was within the ALD OT's remit and appropriate to their role. The OT IPA further advised the ALD OT referred the recommendations for adaptations to the Housing Executive using the Tool Kit form, which was completed appropriately.

60. The OT IPA advised that, although the ALD OT did not reference the Social Work Core Assessment '*all about me*' of September 2020 in the assessment, the records indicate the ALD OT consulted the Social Work manager for

information about the client and his family. I note the OT IPA's advice this was reasonable and appropriate.

61. I note the OT IPA's advice the records for the ALD OT's 2021 assessment are accurate.

62. The OT IPA referenced her advice about the 2014 and 2018 OT assessments in relation to the requirement for the Trust to have a specialist OT in place in response to changing requirements of legislation and strategies around autism. She advised, in 2021, in line with good practice of considering the needs of those with autism, the COT referred to a specialist OT for more information and expertise. The OT IPA advised the COT appropriately sought support in an area not within her expertise, in line with professional standards. The OT IPA further advised the ALD OT subsequently took the clinical lead on the assessment because of their experience and level of knowledge and this was appropriate. The OT IPA advised, *'there was no need for a COT to be involved'.*

63. I accept the OT IPA's advice and am satisfied the ALD OT's assessment in 2021 was appropriate. I refer to the complainant's comments that the recommendations made in this assessment have not been fully implemented. However, I consider the Trust's role in the DFG process does not extend to the implementation of recommendations, rather this responsibility lies elsewhere. Therefore, I do not uphold this element of the complaint.

Summary

64. I refer to my findings at paragraphs 31, 46 to 49, 57 and 58 and 63 above. I partially uphold the complaint related to the COT assessment of 2014; fully uphold the complaint about the COT assessment of 2018 and do not uphold the complaint related to the assessment of 2021. In relation to the COT assessment of 2002, I am unable to conclude whether the COT's decisions were appropriate due to the absence of relevant records. However, I consider, in the context of that period, the COT appropriately considered the client's autism and the wider family's needs and appropriately consulted other professionals. Therefore, I partially uphold Issue one of the complaint.

Injustice

65. I considered carefully whether the failures in care and support caused an injustice to the client and his family. I consider the client lost the opportunity for optimum OT assessments, including consideration of longer-term needs. I refer to the complainant's comments about the impact of the lack of future planning on the client. I consider the failures had a negative impact on the client's wellbeing. I also consider the failures caused the client and his family frustration, anger, anxiety and uncertainty about the appropriateness of the OT assessments and the client's future independence.

Issue 2: Whether Children's Services carried out appropriate and timely assessments, particularly in relation to the provision and delivery of Speech and Language Therapy and Positive Behaviour Support

Detail of Complaint

66. The complainant said the Trust failed to provide the client with consistent and appropriate access to Speech and Language Therapy (SLT) and Positive Behaviour Support (PBS) throughout his lifetime. The complainant said there were no annual reviews and, although assessments were completed, the Trust did not implement associated actions.

Evidence Considered

Legislation/Policies/Guidance

67. I considered the UNOCINI Guidance and the Autism Act. Relevant extracts are either included in the Social Worker Independent Professional Advisor's (SW IPA) advice at Appendix five or at Appendix six, as appropriate.

Relevant Trust Records

68. I considered the client's contact records and documentation for the periods November 2000 to July 2015 and the client's UNOCINI assessment and associated documentation.

Relevant Independent Professional Advice

SW IPA advice

69. The SW IPA provided detailed advice about the support and services the Trust provided to the client and his family from the beginning of its involvement until 2021, a period of approximately 21 years. The complete advice is at Appendix five. A summary of the SW IPA's advice about this issue of complaint, and which concerns the period in which the client was under Children's Services' remit over approximately 14 and a half years, is included in paragraphs 70 to 81 below.

PBS referrals

70. The SW IPA advised, in the July 2001 assessment, the Trust Social Worker(s) (TSW) should have looked at whether an onward referral to PBS was required to offer the client's parents access to advice and information about strategies for dealing with the client's tantrums. The SW IPA advised the December 2003 assessment provided specific details of needs, including training for the client's mother about behavioural management; however, there was no evidence which '*demonstrates how the [T]SW progressed'* this. The SW IPA advised this was important as the 2003 assessment '*indicates that this was a family approaching or in the midst of a crisis in terms of their ability to continue to care for and support the client'.* The SW IPA advised he would *'have expected a more comprehensive SW response to the family's assessed needs … facilitating the provision of 7 hours of domiciliary care for the client each week was not an adequate response.'* The SW IPA referenced the TSW 2005 assessment, which identified a need to refer the client to PBS. He advised the TSW did not make the referral for a further three months. The SW IPA advised the referral should have been made as soon as possible after the August 2005 assessment. The SW IPA advised, between November 2005, when the client was referred to PBS, and the MDT in May 2008 and further, following the MDT, '*there was an inadequate level of [TSW] contact with the family'* which '*only increased prior to the MDT'.*

71. The SW IPA advised the records indicate PBS then began working with the client and his family before March 2006, with PBS completing a report in May

2006 in response to the November 2005 referral. Further, the SW IPA advised, in January 2009 the TSW suggested the family could access help from PBS in relation to the impact of the client's behaviour on family activities. The SW IPA advised, the client's mother, however, declined this suggestion. The SW IPA advised, in consideration of the '*low level of [T]SW involvement with the client and his family through the latter part of 2008 and during 2009'*, the TSW should have paid '*more attention*' to the behavioural support the client and his family needed in the context of the family's decision not to re-access PBS.

SLT referrals

72. The SW IPA referenced records of the client's access to SLT. The SW IPA advised this did not appear to originate with TSW. The SW IPA advised, during the client's time within Children's Services, there were family requests and identified need for further SLT. The SW IPA advised the Initial Assessment detailed the need for liaison with '*other professionals'*, including SLT. The SW IPA advised there were no records to indicate if or how the TSW progressed the client's access to SLT. The SW IPA advised the TSW should have considered if a referral to SLT was required and actioned if appropriate. The SW IPA advised this would have allowed the client's parents access to information and advice about how they could best help the client with his language skills. The SW IPA advised the 2003 assessment identified the client's need for additional SLT but there were no records to indicate if, or how this was progressed.

73. The SW IPA advised the assessment in 2005 was comprehensive, but the associated plan did not address the family's request for additional SLT. The SW IPA advised, in the period following the 2008 MDT and the end of 2009, there were no references to the TSW progressing the client's access to SLT. The SW IPA advised this should have been addressed. The SW IPA advised, in 2011, the client was in receipt of SLT but there was '*no indication in the records that [the TSW] facilitated'* this.

74. The SW IPA advised the UNOCINI assessment of 2014 was of a good standard; however, the associated plan of care did not include any target dates

for actions, including liaison with SLT. The SW IPA advised, as the records do not provide sufficient details of what the TSW did to progress the plan of care from June 2014 onwards, the information recorded suggests the TSW did not follow-up on all the agreed actions. The SW IPA advised this included investigating alternative forms of respite care for the client, when those originally proposed had not worked and liaising with SLT.

Overall Support, Communication, Contact and Assessments in Children's Services

75. The SW IPA advised, Children's Services' assessments '*lack consistency in terms of quality*' and '*in general, there is a lack of clear recommendations and a lack of follow-up after completion of the assessments'*. The SW IPA advised the July 2001 assessment did not state if the TSW followed-up the actions in the March 2001. The SW IPA advised the July 2001 assessment '*lacks depth, does not pull together information about [the client] from the other professionals involved with him, does not adequately identify [the client] and his family's needs and wishes and does not specify the actions that need to be taken moving forward'*. The SW IPA advised the December 2003 assessment was of a higher quality; however, it did not detail enough specific recommendations. The SW IPA advised the plan to address the family's needs, from the August 2005 assessment and the subsequent follow-up on actions were inadequate. The SW IPA advised there is no *'solid information'* about how the actions and recommendations of the 2001 and 2003 assessments were followed up by the TSW. The SW IPA further advised there are assessments that are either unsigned and/or unauthorised.

76. The SW IPA advised, during the period of Children's Services' involvement with the client and his family over almost fifteen years, TSW support and communication with the family varied within and across years. The SW IPA advised there were long periods when there was little or no TSW contact with the family. The SW IPA advised '*an appropriate pattern of assessments, plans and reviews which would have … monitored and tracked'* the TSW responsibilities were missing. The SW IPA advised, in the absence of these, TSW contact with the family '*drifted*' and was mainly reactive in nature, arising

from occasions when the family contacted Children's Services. The SW IPA advised, '*this has also made it difficult, if not impossible to track whether the [T]SWs made appropriate referrals throughout their involvement with the family, to the agencies who could have provided them with appropriate support'.*

77. The SW IPA advised, the records indicate there was little to no TSW contact with the client or his family between early July 2001 and early February 2002 and again during 2002. The SW IPA advised this was '*unsatisfactory*'. The SW IPA advised, in early 2003, the TSW provided support to the family across several areas and then, in December 2003, the TSW completed another assessment which would have required the TSW to spend time with the family; however, between these two periods in 2003, there was little TSW contact with the family which '*would not have been satisfactory'*. The SW IPA advised there was limited TSW contact with the family in 2004, with long periods of no contact and this pattern continued in 2005, 2006 and 2007. The SW IPA advised, the TSW did provide some specific support for the family in 2004 and 2005, including flexible and increased domiciliary support for the client, access to a summer scheme and another assessment in August 2005; however, there is no indication of how the identified actions in the assessment were followed-up. The SW IPA further advised, the TSW failed to arrange the MDT the client's Consultant Psychiatrist recommended in August 2005. The SW IPA advised, when the initial attempt to engage the client's mother in July 2007 was unsuccessful, the TSW did not continue contact from July 2007 until January 2008.

78. The SW IPA advised TSW activity with the family increased in 2008 and included arrangements for respite, appropriate referrals, liaison with the client's Consultant Psychiatrist and facilitation of an MDT. The SW IPA advised there was then no TSW contact with the family for six months in 2009 but, later that year, the TSW re-engaged with the family and provided a range of support, including investigating how to support the family to cope with the client's behaviour, further consideration of respite and an increased DP package. The SW IPA advised, from mid-2010, although the TSW provided some support, there was a further drift in contact, which re-emerged mid-way through 2011.

The SW IPA advised, in 2012, the TSW contact was much more regular with a focus on support for the client's mother in response to her needs, following the client's diagnosis of epilepsy. The SW IPA further advised, however, the TSW did not appear to consider other respite options when the original proposal was unsuccessful.

79. The SW IPA advised, in 2013, until mid-July, TSW involvement again increased, with TSW completion of the client's UNOCINI assessment and his mother's Carers assessment. The SW IPA advised, however, from mid-July to early December, there was no further contact, although this was a '*crucial time for them given that it was leading up to the client's transition to Adult Services'.* The SW IPA advised, in 2014, the contact significantly improved as the TSW *'had an appropriate amount of contact with the family',* including support for a DFG, provision of Outreach support, increased DP and a '*good quality application for daytime services'* in preparation for the client leaving school. The SW IPA advised, however, during the first half of 2015, the TSW had very little contact, which the SW IPA advised was *'not adequate'*, particularly in consideration the client was in the Transition Stage to Adult Services.

80. The SW IPA advised there was no information about how the TSW sought other forms of support for the family about the client's diet and nutrition when the referrals originally made did not come to fruition. The SW IPA advised, following the MDT in 2008, the records indicate the TSW focused on residential respite care provision and access to a summer scheme.

81. The SW IPA advised the TSW's letter, in March 2003, in support of the application for the High-Rate Mobility Component was '*fit for purpose'*. The SW IPA advised the TSW also progressed the family's request for Direct Payments (DP).

Responses to the Draft Investigation Report

Trust response

82. The Trust accepted the findings and recommendations related to Issues two to six.

Analysis and Findings

PBS referrals

83. The SW IPA advised, in 2001, the TSW did not consider if a referral to PBS was required. The SW IPA advised, in 2003, there was no evidence of progression of the family's identified need for training about behavioural management, but this was important because the family was '*approaching or in the midst of a crisis'* and the provision of additional domiciliary care was '*not an adequate response.'* I note the SW IPA's advice, the TSW did not refer the client to PBS until three months after the need was identified; however, this should have been made as soon as possible after the assessment. The SW IPA further advised, from January 2009, when the family's need for support with the client's behaviour was identified but the family declined the suggestion of accessing PBS again, the TSW should have taken further steps to consider this need; however, there was a '*low level'* of TSW involvement in 2009.

SLT referrals

84. The SW IPA advised, whilst the client was in Children's Services, his access to SLT did not appear to originate with TSW. The SW IPA advised, however, whilst in Children's Services, there were both identified need and family requests for further SLT at several points, but there were no records to indicate if or how the TSW progressed this. The SW IPA advised, the TSW should have addressed this. I note the SW IPA advised, in 2011, the client was in receipt of SLT but there was '*no indication in the records that this was facilitated'* by the TSW. The SW IPA advised the plan of care associated with the UNOCINI assessment of 2014 had no target dates for actions, including liaison with SLT. The SW IPA further advised the information recorded, following the UNOCINI

assessment in June 2014 '*suggests the TSW did not follow-up on all the agreed actions, including … liaising with SLT'.*

Overall Support, Communication, Contact and Assessments in Children's Services

85. I refer to the SW IPA advice at paragraphs 70 to 81 above. The SW IPA advised the assessments in Children's Services were of inconsistent quality and there was a '*lack of follow-up'* on actions. I note the SW IPA advised, during the period of Children's Services' involvement with the client and his family over almost fifteen years, TSW support and communication with the family varied within and across years. The SW IPA advised there were long periods when there was little or no TSW contact with the family. The SW IPA advised the TSW contact was mainly reactive in nature, arising from occasions when the family contacted Children's Services. The SW IPA advised, '*this has also made it difficult, if not impossible to track whether the [T]SWs made appropriate referrals throughout their involvement with the family, to the agencies who could have provided them with appropriate support'.* The SW IPA advised where there were lengthy gaps in contact, this was *'unsatisfactory'* and during these periods, the TSW '*should have been implementing the actions documented in the assessment/s.'* The SW IPA also advised, the TSW failed to arrange the MDT recommended by the client's Consultant Psychiatrist in August 2005.

86. The SW IPA cited some examples of when the TSW initiated options for support, for example respite, and advised the TSW did not pursue other possibilities or approaches when the family either declined these or were unsuitable. The SW IPA advised, in the second half of 2013 there was no TSW contact, although this was a '*crucial time for them given that it was leading up to the client's transition to Adult Services'.* The SW IPA further advised, during the first half of 2015, there was again limited contact, which the SW IPA advised was *'not adequate'*, particularly in consideration the client was in the Transition Stage to Adult Services.

87. I note the SW IPA's advice included details of those TSW assessments which were of an appropriate standard. The SW IPA also provided advice on when the TSW provided appropriate support and contact to the client and his family.

88. I accept the SW IPA's advice. Whilst I consider there were aspects of the TSW support, assessments and contact which were appropriate, I am satisfied there is sufficient evidence, during the period of involvement with Children's Services, the Trust did not consistently carry out appropriate and timely assessments and ensure the implementation of associated actions to address the client and his family's needs. This included the provision and delivery of SLT and PBS. I consider this constitutes a failure in care and support and therefore, I uphold this issue of complaint.

Injustice

89. I considered carefully whether the failure in care and support caused an injustice to the complainant and his family. I consider the client and his family lost the opportunity for consistent, timely and appropriate assessments and services. I also consider the complainant and his family experienced frustration, anxiety and uncertainty about the appropriateness and level of the assessments and services provided to the client.

Issue 3: **Whether the Trust appropriately managed the transition from Children's to Adult Learning Disability Services**

Detail of Complaint

90. The complainant said there was no structured process of transition for the client from Children's Services to Adult Learning Disability Services (ALD), which then further led to a lack of services, and support for the client from when he was 17/18 years old.

Evidence Considered

Legislation/Policies/Guidance

91. I considered the Transition Draft Action Plan; the NICCY Review; HSCB RASDN; and the Autism Act. Relevant extracts are either within the SW IPA's advice at Appendix five or at Appendix six, as appropriate.

Relevant Trust records

92. I reviewed the UNOCINI assessment and associated documentation, the Trust's Social Work records for the period September 2015 to September 2017 and the Trust's Chronology, included at Appendix three.

Relevant Independent Professional Advice

SW IPA advice

93. The SW IPA advised there is an incomplete picture of the work undertaken to implement the client's plan of care of June 2014. The SW IPA advised, a review of the plan at the point when the client made the transition to ALD is missing. The SW IPA advised, the review should have included consideration of the status of actions, as well as recommendations about how the necessary actions could be progressed. The SW IPA advised '*the low level of contact between the SW and the family'* between January 2015 and the transfer of the case to ALD in September 2015 was '*of concern given how significant the transition period would have been for the client and his family'.*

94. The SW IPA provided advice about the Trust's statement the UNOCINI assessment of June 2014 is the *'transition report'.* He advised, policy and practice in relation to transition from Children's to Adult Services in Northern Ireland '*is likely to have moved on since the client's UNOCINI assessment was completed*' in June 2014. The SW IPA advised, the Transition Draft Action Plan, which meets the requirements of recommended practice in relation to transition to adulthood, would have been in place when transition planning for the client began in 2014. The SW IPA further advised, however, it is unclear if the Trust applied the recommended framework at the time, but it appeared to be now in place. The SW IPA advised, the Trust did act in line with its own

policy and procedure by completing a UNOCINI assessment and allocating a Transition Officer. The SW IPA further advised, however, the transition process is not a single event but rather is a '*gradual process of supporting a young person and their family through the young person's teenage years and into adulthood, building up the young person's confidence and their ability to manage / cope with the care and support that they need.'* The SW IPA advised, *'ideally the process should begin when the young person is 14 years old'* and 'the years in which a young person is approaching adulthood should be full of opportunity' with '*young people with disabilities and carers … among the groups of people with the lowest life chances.'*

95. The SW IPA advised, a Transition Plan should be drawn up following completion of the Transition Assessment, which should be updated when it is confirmed the client will be moved to ALD. The SW IPA advised, consideration should be given to any of the client or family's need, met by Children Services but which were not available in ALD. He advised the timing of the Transition Assessment was important as it pre-dated the client's move to ALD by more than a year and there might be changes in circumstances. The SW IPA advised, there should be no gap in the provision of care and support to the young person during their transition from Children's Services to ALD. The SW IPA advised, in the client's case, the TSW was the lead professional involved in his care.

96. The SW IPA advised the Trust conducted the client's UNOCINI assessment *'well in advance of'* his move to ALD. The SW IPA highlighted the aspects of the assessment which were appropriate. He also highlighted gaps in the assessment. These included that the assessment did not indicate how the TSW sought the client's views; the client's Plan of Care outcomes were generally focused on the present rather than future needs and aspirations; and did not consider differences in support and services available to the client in Children's Services and ALD. The SW IPA advised, the UNOCINI assessment provides a very good picture of the client and his family's circumstances and needs at the time of the assessment, but the outcomes relate to immediate and short-term goals and service provisions without '*any consideration of the*

client's transition to Adult Services'. The SW IPA advised, whilst the UNOCINI assessment would provide a good foundation for ALD to plan with the client and his family, '*that planning should have formed part of the UNOCINI Assessment'*. The SW IPA also advised including ALD in the assessment and planning process would have been beneficial. The SW IPA advised, a Transition Plan was completed but not until November 2016, when the client was 18 years old. The SW IPA advised this should have been in place sooner.

97. The SW IPA advised, although in 2013, the TSW worked on the client's UNOCINI assessment and his mother's Carers assessment, there was no contact with the family again for six months, *'despite this being a crucial time for them given that it was leading up to the client's transition to Adult Services'*. The SW IPA advised, during the following year, 2014, the TSW had an appropriate amount of contact with the family but again in the first half of 2015, there was '*very little contact with the client and his family. Given that he was now in the Transition Stage to Adult Services, this was not adequate'.* The SW IPA advised, from September 2015 until January 2016, there is '*no social work activity recorded*' on the client's case for four months and again during the period March to June 2016, '*there is no SW activity recorded'* for three months.

98. The SW IPA advised, the TSW had contact with the family in March 2017; however, even if the TSW attended a meeting at the client's school in November 2016, there would have been no contact with the family for approximately four months. The SW IPA advised these gaps in contact and activity were '*not appropriate*'. The SW IPA advised, if the client's case only needed regular monitoring, the TSW should have agreed a schedule of contact with the family, for example, once a month. The SW IPA advised, during the last period of the Transition Officer's involvement from March to September 2017, there was an increase in social work contact and activity with the family. Overall, the SW IPA advised, '*the [social work] contact with the family and the level of support and communication between the [social workers] and the family … was inadequate in 2015 and 2016, improved in 2017 (and was focused, late in the day, in 2016 and 2017 on the need to secure daytime provision for the client for when he left school in June 2017)'.*

99. The SW IPA advised, as the TSW completed the client's UNOCINI assessment in June 2014, at the point of ALD involvement over a year later, if the Trust used this assessment for the transition process, the TSW should have reviewed and updated the assessment. The SW IPA also advised a handover report from Children's Services to ALD would have been beneficial. The SW IPA advised, on 16 September 2015, the ALD TSW informed the client's teacher the client was now under ALD. The SW IPA advised the TSW should have shared this information with the teacher earlier as part of transition planning. The SW IPA also advised, the TSW should have discussed the client's options, after he left school, earlier as part of Transition Planning.

100. The SW IPA provided advice on the ALD Social Work assessment of need, February 2016. In relation to the transition process, the SW IPA advised the assessment did not provide sufficient information about services being provided to identify gaps in provision; would benefit from additional information about the client's needs for a daytime placement; did not contain adequate considerations about transition, including how his transition to Adult Services will be managed. The SW IPA advised, overall, this assessment '*lacks depth and detail in several areas'* and '*would not make it easy for the client's needs to be specified'.* The SW IPA provided advice about the Carers Support and Needs Assessment, completed in June 2017 during the period of transition. He advised, the assessment '*is too brief / lacks detail'* and overall '*is not thorough enough … it does not provide enough specifics about the family's needs and so makes it difficult to identify the specific support (referrals, signposting) etc. that needs to be sought.'*

Responses to the Draft Investigation Report

101. Please refer to paragraphs 82 and 83 above.

Analysis and Findings

102. In the Trust documentation provided, the last reference to the Transition Officer is in September 2017. I note, during this period, there were three and a half months from September 2015 to January 2016 when there was no social work contact or support; from February to June 2016 there was another period of

three and a half months when there was no social work contact; and between August 2016 and March 2017, there was a period of seven months without social work contact, although in this period of time, there was some social work support activity. Further, although the TSW agreed to refer the client to Psychology in mid-February 2016, the TSW did not progress the referral until a month later. Over a period of 25 months, I note there was no social work contact for a total of 14 months.

103. The Trust stated, its standard practice[2], at that time, was for a Transition Officer to work with a client and their family from six months before their eighteenth birthday. The Trust stated, during this process there is close multi-disciplinary working and information sharing, including with relevant external agencies that provide day opportunities or further education. The Trust stated it followed this process in the client's case. The Trust provided a community social work chronology for the period of August 2015, the client's eighteenth birthday, until 2021. I note the chronology indicates the initial home visit by the Transition Officer took place in September 2015, after the client turned 18. I consider this does not accord with the Trust's stated process. The Trust also stated the UNOCINI assessment, dated June 2014, is the transition report. The Trust stated the Community Social Work team had ongoing involvement with the client since his transition to ALD in 2015. I note the Trust acknowledged and apologised for the failure to conduct formal annual reviews with the client for six years from the period of transition in 2015 until December 2021. The Trust stated, learning identified from the complaint included the need to both conduct annual reviews with all service users in a timely manner and have regular meetings and communication with the family and all professionals involved to ensure the client's assessed needs are met. The Trust stated there was no referral to SLT at the time of the client's transition.

104. The SW IPA advised, the Trust acted in accordance with its own policy and procedure for transition at that time; however, there was also a framework for recommended practice for transition in place at the time. The SW IPA

[2] There was no written procedure or guidance provided in relation to transition in the Trust at that time. The Trust, however, provided a description of its standard practice

referenced the Trust's statement the UNOCINI assessment was the transition report and further advised the transition process is not a single event. I note the SW IPA advised there were gaps in the UNOCINI assessment, including outcomes which were focused on the present rather than future needs as the client approached adulthood. The SW IPA advised, because the Trust completed the UNOCINI assessment in June 2014 and it used this assessment for the transition process, the Trust should have reviewed and updated the assessment at the time of transfer to ALD 15 months later; and further, a handover report would have been beneficial. The SW IPA advised a Transition Plan should be drawn up after the Transition Assessment, to be updated in line with changing needs as time elapses. The SW IPA advised, a Transition Plan was completed but not until November 2016, when the client was 18 years old and which he advised should have been in place sooner.

105. I note the SW IPA advised the ALD Social Work assessment of need of February 2016 did not provide sufficient information about services being provided to identify gaps in provision for the transition process; and did not contain adequate considerations about transition. The SW IPA advised this assessment '*lacks depth and detail in several areas'* and '*would not make it easy for the client's needs to be specified'.* In relation to the Carers Support and Needs Assessment of June 2017, during the period of transition, the SW IPA advised the assessment '*is too brief / lacks detail'* and overall *'is not thorough enough … mak[ing] it difficult to identify the specific support (referrals, signposting) etc. that needs to be sought.'* The SW IPA advised liaison with the client's teacher about his transition to ALD and discussions with the family about his options after he left school should have taken place earlier as part of transition planning.

106. The SW IPA advised *'the low level of contact between the SW and the family'* between January 2015 and September 2015 was '*of concern given how significant the transition period would have been for the client and his family'.* The SW IPA advised, during 2013, there was no contact with the family for a period of six months, '*despite this being a crucial time for them given that it was leading up to the client's transition to Adult Services'* and in the first half of

2015, there was again, *'very little contact with the client and his family. Given that he was now in the Transition Stage to Adult Services, this was not adequate'*. The SW IPA also advised there is '*no social work activity recorded'* on the client's case for four months from September 2015 to January 2016 and for three months, from March to June 2016.

107. The SW IPA advised, certainly between November 2016 and March 2017, there was no contact with the family, a period of approximately four months. The SW IPA advised these gaps in contact and activity were '*not appropriate'.* The SW IPA advised, the TSW should have agreed a schedule of contact with the family, for example, once a month. The SW IPA advised, during the last period of the Transition Officer's involvement from March to September 2017, there was an increase in social work contact and activity with the family. I note the SW IPA advised, overall *'the [social work] contact with the family and the level of support and communication between the [social workers] and the family … was inadequate in 2015 and 2016'.* The SW IPA advised there should be no gap in the provision of care and support during the transition.

108. I consider the Trust did not act in accordance with its stated practice at the time of the client's transition process. This is because the Transition Officer did not commence work with the client and his family until after his eighteenth birthday, when this should have occurred at least six months earlier. Whilst I accept the SW IPA's advice the application of the UNOCINI assessment as a transition mechanism was, at that time, in keeping with the Trust's own policy, I also accept his advice there was a recommended practice framework in place at that time in Northern Ireland. I consider the Trust's failures to act in accordance with both its own stated practice and the recommended practice do not accord with the first Principle of Good Administration, 'Getting it right' which requires public bodies to act in line with its own policy and guidance; and take proper account of established good practice. I consider this constitutes maladministration.

109. Further, I consider the records indicate there were significant gaps in social work contact during the transition period, which accords with the SW IPA advice on this. I accept the SW IPA's advice that the level of contact and activity were not appropriate. I also accept the SW IPA's further advice; specifically, there were gaps in the Trust's assessments which were pertinent to the identification of the client and his family's needs both during transition and into adulthood; the UNOCINI assessment was not updated on the client's transfer to ALD, in spite of a time-lapse of over a year; and there should have been earlier interventions in relation to the creation and implementation of a transition plan, discussions about options for the client after leaving school and liaison with his school. Therefore, I find the Trust did not appropriately manage the client's transition from Children's Services to ALD. I find this constitutes a failure in care and support. I also refer to my finding in the paragraph above and uphold this issue of complaint.

Injustice

110. I considered carefully whether the failure in care and support caused an injustice to the complainant and his family. I consider the client and his family lost the opportunity of receiving an appropriate period of transition to ALD. I also consider the complainant and his family experienced frustration, anxiety and uncertainty both about the transition process and the provision of future services.

Issue 4: Whether Adult Learning Disability Services carried out appropriate and timely assessments in relation to the provision and delivery of Speech and Language Therapy, Positive Behaviour Support, psychological and physical therapies

Detail of Complaint

111. The complainant said the client did not receive any services whilst under the remit of Adult Learning Disability Services (ALD). The complainant said he believed there was a lack of understanding of the client's complex needs, which translated into a failure to provide appropriate and consistent services. The complainant specified the Trust's failure to provide the client with appropriate

and consistent access to Speech and Language Therapy (SLT) and Positive Behaviour Support (PBS) whilst in ALD.

Evidence Considered

Legislation/Policies/Guidance

112. I considered the NISCC Social Work Standards; HSCB RASDN; and the Autism Act. Relevant extracts are either within the SW IPA's advice at Appendix five or at Appendix six, as appropriate.

Relevant Trust records

113. I further reviewed the Trust's Social Work records for the period October 2017 to December 2021 and the Trust's Chronology, included at Appendix three.

Relevant Independent Professional Advice

SW IPA advice

114. The SW IPA advised, during 2017, the TSW completed the required assessments, made necessary referrals to other agencies, liaised with the family in relation to DP and continued to work on securing daytime provision for the client.

115. The SW IPA advised there did not appear to be any TSW contact with the family at all in 2018, for which he could *'see no justification … given the complexity of the needs presented by the client and the numerous references to the impact that these needs were having on his family (particularly his mother)'.* The SW IPA advised, in 2019 TSW contact with the family became '*sporadic*' again, '*with lengthy gaps between contacts'*. The SW IPA advised, in this period, the records do not refer to the TSW completing any assessments with the client or about liaison with or referral to other agencies.

116. The SW IPA advised TSW contact with the family increased significantly from the beginning of 2020 onwards with the client's TSW changing in February 2021. The SW IPA advised, although this included a period when there were restrictions on face-to-face contact due to Covid-19, the TSW regularly phoned

the family, undertook six home visits in 2020, supported the family with applications, completed appropriate assessments, monitored DP and made appropriate referrals to other agencies. The SW IPA advised, however, he was unable to determine from the records provided if, during 2020 and 2021, the TSW actioned everything agreed following assessment and planning processes.

117. The SW IPA advised on the appropriate aspects of the ALD Assessment of Need, February 2016. He advised it contains only brief information about the client's physical health. I refer to the SW IPA's advice about this assessment in Issue three and which he advised, '*lacks depth and detail in several areas'.* The SW IPA advised on the Carers Support and Needs Assessment of 2017. He advised the description of the client's physical health was '*inadequate'.* I also refer to his advice about this assessment in Issue three and which he advised was not '*thorough enough*', was '*too brief/lacks detail'* and did not provide the necessary information to identify the specific support required to meet needs.

118. The SW IPA provided advice on the three plans, 'My Care' and the Self-Directed Support Plans of March 2019, February 2020 and June 2020. He advised these were '*of a good standard*'. The SW IPA also provided advice on the Core Assessment 'All About Me' of 20 April 2020. The SW IPA advised this assessment was 'o*f a good standard and contains a lot of relevant information. There are details in this assessment that I have not seen in other assessments regarding the client'.* The SW IPA further advised, however, in the context of the *'good quality of the assessment … the recommendations could have been more specific'.* The SW IPA advised the assessment notes the client did not have a Behaviour Support Plan in place. The SW IPA advised, the TSW made a referral to 'Psychologies Therapies' but did not indicate when the referral was made. The SW IPA advised it was recorded the client was on a waiting list for this service. The SW IPA advised the assessment should have detailed how the TSW intended to follow-up the referral to PBS. The SW IPA advised, in the context of the length of time the client had waited for behavioural support, the TSW should have been proactive in pursuing this. The SW IPA also advised there were no references to SLT.

119. The SW IPA provided advice on the assessment of 25 September 2020. He advised this assessment was of a *'high standard'.* The SW IPA advised there is a '*set of clear and specific recommendations that link to [the client's] assessed needs. The assessment shows that the [TSW] had already made a number of necessary onward referrals … and is clear about what follow up work she intended / committed to do.'* The SW IPA detailed the TSW's activity. This included an urgent referral for Community Physiotherapy in October 2020, which service assessed the client the following month, although the client did not receive further services from Physiotherapy following this. The TSW also progressed access to SLT by November 2020 and Consultant Psychiatrist review by January 2021. The SW IPA advised the TSW '*appropriately'* followed-up on the recommendations made in the September 2020 assessment. The SW IPA advised, the only record of referral to Physiotherapy whilst in ALD related to this assessment.

120. The SW IPA provided advice on the impact of the delay in the client accessing PBS from 2016 to 2020. He advised, the client was originally referred when he was approximately 19 years old, but this was not actioned until he was 23. The SW IPA advised this period of life can be challenging for any young person because of changes but in the context of the client's autism and moderate learning disability, it would be reasonable to conclude he struggled with change, particularly changes in routine. The SW IPA advised this was documented in Social Care assessments. The SW IPA advised, the client presented with specific emotional and behavioural challenges, which would probably have been exacerbated by the life changes he was experiencing. The SW IPA advised, the absence of support for his family in dealing with his behaviour would be '*unacceptable given that his emotional and behavioural issues are well documented and were longstanding. His family should not have been left to deal with such issues without professional support.'*

121. The SW IPA questioned the failure to action the PBS referral for four years in the context that the TSW should have followed this up across this period. The SW IPA advised, he could find no evidence the TSW followed-up the 2016 PBS referral and '*given how crucial this support was to the client and his family, they*

should have done so'. The SW IPA referenced the Trust's statement there was an error in processing the referral and advised, if the referral had been followed up, this error might have been identified earlier which would have reduced the time it took for the referral to be actioned. The SW IPA advised, the delay in the PBS referral would have had a negative impact on the client and his family.

122. The SW IPA also questioned the absence of SLT whilst in ALD from 2016 to 2020. The SW IPA advised, the TSW should have considered how the client's needs around SLT and support with communication were being met. The SW IPA advised he could not identify any references to the ALD TSW referring the client to SLT until 13 August 2020. The SW IPA also advised PBS referred the client to SLT on 6 September 2020. The SW IPA advised, given the '*numerous references to [the client's] communication issues'*, the TSW should have made a referral to SLT sooner. The SW IPA advised the assessment process should have identified this as a need with a follow-up documented action in the plan of care.

Responses to the Draft Investigation Report

123. Please refer to paragraphs 82 and 83 above.

Analysis and Findings

124. The records of September to December 2017 indicate there was a period of three months without TSW contact with the family and then a further three months, until March 2018, during which the TSW did not make contact. At that time, when the TSW was unable to speak with the family, the TSW made no further attempts to make contact until January 2019, approximately ten months later. Therefore, whilst under ALD, I note the family had no contact with the TSW for a continuous period of almost one year. The records also indicate, during the period March to August 2019, there were a further five months without contact and even then, the family initiated the contact. I further note, in this period of approximately 24 months, there were 21 months in which there was no social work contact with the family. I also refer to paragraph 103 and the period of 25 months during transition in ALD when there was no social work contact for 14 of these months. Overall, therefore, across a period of four

years, there was approximately three years of no social work contact. The records do indicate there was an increase in the level and consistency of social work contact and activity from September 2019.

125. The Trust acknowledged there was a significant delay in providing the PBS to the client and the client should have had access to a full PBS assessment in a timely manner. The Trust stated there are now systems in place to prevent errors in processing referrals. I note the Trust stated the client was not referred to ALD SLT at the time of transition and was only referred on 13 August 2020. The Trust stated the client's first face-to-face appointment with ALD SLT was on 23 September 2020.

126. The SW IPA advised, although during the period 2020 to 2021, TSW contact and activity was appropriate, there did not appear to be any TSW contact in 2018. The SW IPA advised again in 2019 TSW contact was *'sporadic'* and, during which period, there are no records of the TSW completing assessments or liaison with or referrals to other services. I note the SW IPA advised there was 'n*o justification [for this] … given the complexity of the needs presented by the client and the numerous references to the impact that these needs were having on his family (particularly his mother)'.* I also refer to the SW IPA's advice about TSW contact and support detailed in Issue three.

127. The SW IPA provided advice on the assessments completed in ALD. He advised the 2016 Assessment of Need *'lacks depth and detail in several areas'*; and the 2017 Carers Support and Needs Assessment was '*too brief/lacks detail'* and did not provide the necessary information to identify the specific support required to meet needs. The SW IPA advised the plans of March 2019, February 2020 and June 2020 were '*of a good standard*' and the April 2020 Core Assessment 'All About Me' was also '*of a good standard*', although '*the recommendations could have been more specific'.* The SW IPA advised, there is reference to the TSW referring the client to 'Psychologies Therapies' from the April 2020 assessment but it is unclear when the referral was made. The SW IPA advised, as the client was placed on a waiting list for this service, the assessment should have detailed how the TSW intended to follow-up the

referral to PBS. I note the SW IPA advised, in the context of the length of time the client had waited for behavioural support, the TSW should have been proactive in pursuing this. The SW IPA also advised there were no references to SLT in this assessment.

128. The SW IPA advised the September 2020 assessment was of a '*high standard'* and there is evidence the TSW '*appropriately'* followed-up the recommendations in this assessment. I note the SW IPA advised this included an urgent referral for physiotherapy in October 2020 but also this was the only record of referral to physiotherapy whilst in ALD.

129. The SW IPA advised, given the client's needs, it would be reasonable to conclude he struggled with change and the absence of support for his family in dealing with his behaviour would therefore be *'unacceptable given that his emotional and behavioural issues are well documented and were longstanding. His family should not have been left to deal with such issues without professional support.'* The SW IPA questioned the failure to action the PBS referral for four years in the context that the TSW should have followed this up across this period. I note the SW IPA advised there was no evidence the TSW followed-up the 2016 PBS referral and '*given how crucial this support was to the client and his family, they should have done so'*. The SW IPA advised, if the referral had been followed up, the administrative error, which the Trust stated led to the delay, might have been identified earlier which would have reduced the time it took for the referral to be actioned. The SW IPA advised the delay in the PBS referral would have had a negative impact on the client and his family.

130. The SW IPA questioned the absence of SLT whilst in ALD from 2016 to 2020. The SW IPA advised there were no references to the ALD TSW referring the client to SLT until 13 August 2020. I note the SW IPA advised, given the *'numerous references to [the client's] communication issues',* the TSW should have made a referral to SLT sooner and the assessment process should have identified this as a need with a follow-up documented action in the plan of care.

131. I refer to the NISCC Social Work Standards. I consider the level of TSW contact, support and activity during the period of the client's involvement with ALD, until late 2019, did not accord with these standards. The Trust acknowledged there was a significant delay in the client's referral and access to PBS, which the Trust stated should not have occurred. The Trust also confirmed there was no referral to SLT until August 2020, by which time, the client was under ALD's remit for approximately five years.

132. I accept the SW IPA's advice there was '*no justification'* for the level of TSW contact and activity during the period in ALD until 2020. I also accept his advice the TSW contact and activity in 2020 and 2021 was appropriate. I accept the SW IPA's advice that, prior to September 2020, to varying degrees, there were gaps in the TSW assessments and associated actions. I accept the SW IPA's advice there were no references or referrals to physiotherapy prior to September 2020. I also accept the SW IPA's advice the delay in access to PBS was *'unacceptable*' and would have had a negative impact on the client and his family; and the TSW should have followed-up the 2016 PBS referral and ensured the client's needs related to communication and SLT were identified in the assessment process earlier. Whilst I consider there were appropriate assessments and referrals from 2020 onwards, I find the Trust failed to undertake appropriate and timely assessments with the client and his family, including those related to the provision and delivery of SLT, PBS, psychological and physical therapies. I consider this constitutes a failure in care and support. Therefore, I uphold this issue of complaint. I also refer to my findings in Issue five about the concerning gap in services and reviews, which is further reflected here.

Injustice

133. I considered carefully whether the failure in care and support caused an injustice to the complainant and his family. I consider the client and his family lost the opportunity of receiving appropriate support from PBS and psychological therapies and therefore the opportunity for improved mental health. I consider the client lost the opportunity of receiving appropriate SLT and physiotherapy and therefore the opportunity of improved physical health

and communication skills. I also consider the complainant and his family experienced frustration, anxiety and uncertainty about the provision of future services and unnecessary stress in dealing with the client's behavioural issues without appropriate support. Further, I recognise the complainant's view and his clearly understandable concerns that the gap in services of approximately five years had a significant impact on the client's language skills and behaviour, as these deteriorated as he got older.

Issue 5: Whether Adult Learning Disability Services performed appropriate reviews (annual and multidisciplinary)

Detail of Complaint

134. The complainant said the Trust did not review the client on an annual or regular basis whilst in Adult Learning Disability Services (ALD). The complainant also raised concerns about the lack of multi-disciplinary input and review in the client's case.

Evidence Considered

Legislation/Policies/Guidance

135. I considered the NISCC Social Work Standards; HSCB RASDN and the Autism Act. Relevant extracts are included either within the SW IPA's advice at Appendix five or at Appendix six, as appropriate.

Relevant Trust records

136. I reviewed the Trust's Social Work records for the period September 2015 to December 2021 and the Trust's Chronology, included at Appendix three.

Relevant Independent Professional Advice

SW IPA advice

137. The SW IPA advised the client's first review in ALD was in February 2021 and, therefore, there were no case management reviews for more than six years. The SW IPA advised *'reviews on any case [should] … be done on an annual basis'.* The SW IPA advised the Trust has acknowledged this in relation to the

client and apologised to the complainant for this. The SW IPA advised the first review after the client's transfer to ALD did not happen but would have been *'particularly important'* because of the support needed through the imminent significant changes to his life. The SW IPA advised, the absence of reviews meant there was no forum for multi-disciplinary planning and information sharing, including with the family. The SW IPA advised, because of this, there was no mechanism for professionals to take ownership of necessary actions, other than the TSW and no structure to review and monitor these, which ultimately led to drift in meeting the client's needs. The SW IPA also advised the absence of a central forum would have resulted in the family having to reiterate information and needs to individual professionals. The SW IPA advised the February 2021 management review had appropriate actions but did not set target dates, which makes it more difficult to hold professionals to account.

Responses to the Draft Investigation Report

138. Please refer to paragraphs 82 and 83 above.

Analysis and Findings

139. The Trust stated it acknowledged in previous communications to the family, and at the client's annual review on 2 December 2021, it did not conduct any formal annual reviews with the client from the point of his transition to ALD in 2015 until December 2021. I note the Trust stated it apologised to the complainant for the lapse in formal annual reviews.

140. The SW IPA advised the client's first review in ALD was in February 2021 and, therefore, there were no case management reviews for more than six years. I note the SW IPA advised reviews should be undertaken annually. The SW IPA advised the first review after the client's transfer to ALD, but which did not take place, would have been '*particularly important*' because of client's support needs during the changes in his life. The SW IPA provided advice on the importance of multi-disciplinary reviews, advising their absence '*led to drift*' in meeting the client and his family's needs.

141. Whilst the Trust acknowledged and apologised for the lack of 'formal' reviews for six years, I refer to the findings in Issues three and four above, where I identified significant gaps in assessments, contact and support during the period of approximately four years from September 2015 until late 2019, which incorporates any 'informal' reviews. I accept the SW IPA's advice the Trust should have undertaken annual multi-disciplinary reviews and their absence affected how the client and his family's needs were met. I consider in ALD, prior to 2021, the Trust failed to undertake appropriate reviews. I refer again to my findings in Issues three and four about the significant gap in services for approximately five years, which together with the absence of reviews for the six-year period to be of concern. I find this constitutes a failure in care and support; therefore, I uphold this issue of complaint.

Injustice

142. I considered carefully whether the failure in care and support caused an injustice to the complainant and his family. I consider the client and his family lost the opportunity for timely and appropriate reviews, including multi-disciplinary input. I also consider the complainant and his family experienced frustration, anxiety and uncertainty about the continued appropriateness and level of the services provided to the client.

Issue 6: Whether the Trust properly addressed the complainant's concerns through the Trust's complaints process.

Detail of Complaint

143. The complainant said he felt the family's attempts to raise concerns and improve the services available to the client *'was shaped into an extremely limited official complaint'* which did not address the family's concerns. The complainant said he did not feel '*there was any meaningful investigation'* or recognition of the damage to the client, following his complaint.

Evidence Considered

Legislation/Policies/Guidance

144. I considered the Principles of both Good Complaints Handling and Good Administration and the DoH Complaints Guidance.

Relevant Trust records

145. I considered the minutes of the Trust's meeting with the complainant on 28 January 2021; the Trust's responses to the complainant, dated 28 January 2021 and 8 March 2021; the letter from the client's advocate of 1 April 2021 and the Trust's response to this of 4 May 2021.
146. I note in the letter of 4 May 2021, the Trust provided a response to each of the 12 questions included in the advocate's letter of 1 April 2021. The minutes of the meeting on 28 January 2021 indicate, due to the nature and length of the discussion about the complainant's first point of concern, there was no discussion about other matters the complainant had raised. The Trust's letter of 8 March 2021 provides responses to Speech and Language (SLT) and Occupational Therapy (OT) issues, whilst Adult Learning Disability Services (ALD) issued a separate response to the complainant, dated 28 January 2021.

Analysis and Findings

147. The Trust's response from ALD of 28 January 2021 provides a response to each question raised by the client's mother in her email of 10 December 2020. The Trust's letter of 8 March 2021 provides responses to SLT and OT issues included in the complainant's email of 16 December 2020. The Trust's letter of 4 May 2021 contained a response to each of the 12 questions detailed in the advocate's letter of 1 April 2021. I note, however, two issues included in the complainant's email of 16 December 2020, concerning physiotherapy and co-ordination of Allied Health Professional (AHP) input to the client, were not fully addressed in any of the Trust's responses. Furthermore, in his email of 16 December 2020, the complainant included 11 '*questions on AHP services'* related to alleged failures in the provision of services to the client. In dealing with the complaint, the Trust incorporated responses to the last of these questions, number 11, which related to OT and DFG applications. I could not

identify, however, in any of the Trust responses or records that the Trust addressed the other ten questions in the complainant's email of 16 December 2020.

148. I consider the Trust addressed issues about OT cited in the correspondence from the complainant's wife, the complainant and the client's advocate of 10 December 2020, 16 December 2020 and 1 April 2021 respectively. I also consider the Trust addressed the issues, additional to OT, detailed in the correspondence of 10 December 2020 and 1 April 2021. I am therefore satisfied the Trust properly addressed these concerns.

149. I cannot find evidence, however, the Trust properly addressed several queries and concerns which the complainant raised in his email of 16 December 2020 related to physiotherapy, co-ordination of AHP services and the majority of those concerning alleged failures in the provision of services to the client. I note the Trust's statements, in response to the investigation enquiries, within which it acknowledged: - the significant delay in providing PBS to the client, to which he should have had access in a timely manner; the client was only referred to ALD SLT in August 2020; and learning applied from the case of the need for inclusion of a specialist ALD OT in assessment of appropriate housing solutions in accordance with assessed need, which service was not available until April 2021.

150. I consider the Trust's failure to address these points during the complaints process does not accord with the DoH Complaints Guidance, particularly 3.44, which stipulates responses to complaints should address the concerns expressed by the complainant and show that each element has been fully and fairly investigated; include an apology where things have gone wrong; and report the action taken or proposed to prevent recurrence. I also consider the Trust failed to act in accordance with the third to the sixth Principles of Good Complaints Handling, '*Being open and accountable*'; '*Acting fairly and proportionately'*; '*Putting things right';* and '*Seeking continuous improvement'.* This is because these Principles, respectively, require public bodies to give honest evidence-based explanations; ensure complaints are investigated

thoroughly and fairly; acknowledge mistakes, apologising where appropriate, provide appropriate remedies in a timely manner, take account of any injustice arising from pursuit of the complaint as well as from the original dispute; and use feedback and lessons learnt to make improvements, telling the complainant about these where appropriate. I consider this failure constitutes maladministration. I therefore uphold this issue of complaint.

Injustice

151. I considered carefully whether the failure caused an injustice to the complainant and his family. I consider the complainant experienced frustration, uncertainty and was unable to move on because he did not feel the Trust properly addressed his concerns, including those associated with the future provision of services to the client. I also consider the complainant had to take additional time and trouble in pursuing the complaint.

CONCLUSION

152. I received a complaint about the Trust's care and support of the client and his family over a period of 21 years from 2000 to 2021. The complaint also concerned how the Trust responded to the complaint. For the reasons outlined in the report, I upheld Issues two to six and partially upheld Issue one of the complaint.

153. In relation to the Trust's provision of care and support to the client and his family, I consider the Trust failed to: -

- Meet the full requirements of relevant legislation and policies in the 2014 and 2018 Occupational Therapy assessments.
  In 2014 and 2018: -
  - the Trust did not have specialist Occupational Therapists in place with autism expertise and did not engage with autism experts;
  - the Trust did not consider the client's wider sensory needs; and
  - the Trust did not consult with other relevant professionals or consider other professionals' assessments.

    - In 2014, the Trust did not consider either the longer-term needs of the client or the client's period of transition to adult services.
    - In 2018, the Trust did not consider the client's behavioural issues.
- Consistently carry out appropriate and timely assessments and ensure the implementation of necessary actions to meet the client and his family's needs while the client was under the remit of Children's Services. This included actions associated with the provision and delivery of SLT and PBS.
- Manage the client's transition from Children's Services to ALD appropriately.
- Undertake appropriate and timely assessments with the client and his family, including those related to the provision and delivery of SLT, PBS, psychological and physical therapies while under ALD.
- Undertake appropriate reviews with the client for the first five years under ALD.

154. I find the significant gap in the provision of services and reviews for approximately five years, during the period of the client's time in ALD, to be highly concerning.

155. I recognise, because of the Trust's failures, the client and his family lost the opportunity for: -
    - optimum OT assessments, including consideration of longer-term needs.
    - consistent, timely and appropriate assessments and services;
    - receipt of an appropriate period of transition to ALD;
    - receipt of appropriate support from PBS and psychological therapy; therefore, the opportunity for improved mental health;
    - receipt of appropriate SLT and physiotherapy; therefore, the opportunity of improved physical health and communication skills; and
    - timely and appropriate reviews, including multi-disciplinary input.

156. I also recognise the complainant's view that, the particularly concerning gap in services during the period after the client's transition to ALD until 2021, had a significant impact on the client's language skills and behaviour, as these deteriorated as he got older. Further, I also recognise the complainant's view

about the impact on the client from the absence of future planning in the OT assessments. Therefore, I recognise this would have had a negative impact on the client's wellbeing.

157. I recognise the failures in care and support would have caused the complainant and his family frustration, anger, anxiety and uncertainty about: - the appropriateness and level of the assessments and services provided to the client, the transition process, the provision of future services and the client's future independence. Further, I recognise the failures would also have caused the complainant and his family unnecessary stress in dealing with the client's behavioural issues without appropriate support.

158. In relation to the Trust's management of the complaint, I consider the Trust did not fully investigate and respond to all the complainant's concerns.

159. I recognise this failure would have caused the complainant frustration, uncertainty, additional time and trouble in pursuing the complaint and the inability to move on.

Recommendations

160. I recommend the Trust provides to the complainant a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustice caused as a result of the failures identified (within **one month** of the date of this report).

161. I also consider there are a number of lessons to be learned which provide the Trust with an opportunity to improve its services. I further recommend the Trust implements an action plan to incorporate the following recommendations and should provide me with an update within **six months** of the date of my final report. The Trust should support the action plan with evidence to confirm the Trust has taken appropriate action (including, where appropriate, records of any relevant meetings).

162. I recommend the Trust reviews its current processes, guidance, training and documentation associated with the OT assessment for adaptations under the DFG process. The review should ensure that, in their assessments, OTs consider all the legislation, guidance, policies and strategies, which the investigation has determined are applicable, but which are additional to the Sick and Disabled Persons Act and the Housing Order. The Trust should provide evidence of the review outcomes to this office. Further, where the Trust identifies that changes are required to ensure compliance, the Trust should provide this office with details of measures to address this. The Trust should also evidence the completion of any necessary actions to this office.

163. Although I note, in 2021, the Trust had a specialist OT in place for assessment of those with autism, I recommend the Trust ensures it continues to meet relevant legislation, policies and strategies in the provision of appropriate OT expertise for those with autism. This should be evidenced by providing an assessment of the current staff capacity and expertise. Where the Trust identifies gaps in provision, the Trust should also provide this office with a mitigation action plan to address this. The Trust should also evidence its completion to this office.

164. I also recommend the Trust should ensure relevant staff, including OTs and social work units, are reminded of the importance of the applicable legislation, guidance, policies, strategies and standards referenced in this report. In relation to social work units, this should include NISCC Social Work Standards and the published standard, '*Records Matter, a view from regulating and oversight bodies on the importance of good record keeping'* (The Public Services Ombudsman, the NI Audit Office and the Information Commissioner's Office, January 2020).

165. I recommend the Trust should review the process of undertaking assessments and monitoring the implementation of actions associated with client needs within Children's Services to ensure effective and consistent management of these. This should be evidenced through a report of the review and follow-up sample audits.

166. I also recommend the Trust should review the process of transition from Children's Services to ALD to ensure appropriate management. This should be evidenced through a report of the review and follow-up sample audits.

167. I further recommend the Trust should review the ALD process of undertaking assessments and identifying and implementing appropriate actions to ensure these meet the needs of clients and their families. This should include consideration of the identification of appropriate referrals to other services, with particular reference to those with complex needs. This should be evidenced through a report of the review and follow-up sample audits.

168. I recommend the Trust should give relevant staff in Occupational Therapy, Children's Services, ALD and those involved in the Transition process the opportunity to reflect on the OT and SW IPAs' full advice in consideration of their own practice. This should be reflected in appraisals and evidenced by records of information sharing.

169. I recommend the Trust should share the findings in this report about how the Trust addressed the complainant's concerns (Issue six) with relevant staff. This should be evidenced by documented records of the information sharing.

170. I welcome the Trust's acceptance of the findings and recommendations related to Issues two to six. I also welcome the Trust's improvement initiative that it will carry out annual reviews in ALD in a timely manner. The Trust should provide evidence of the implementation of this learning through follow-up sample audits.

MARGARET KELLY
Ombudsman **December 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 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.