Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against Belfast Health and Social Care Trust

NIPSO Reference: 18400

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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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SUMMARY

I received a complaint about the Trust's Adult Safeguarding Gateway Team's (ASGT) investigation into an unexplained fracture sustained by the complainant's late aunt (the resident), on 21 June 2016 while she was resident of Nazareth House Care Village, Belfast (the Care Home). The complainant was dissatisfied with the ASGT's decision on 27 July 2016 to close the investigation on the basis that there was *'no evidence to suggest the Care Home have not acted on the care plan or that they have omitted or been neglectful in providing care or have not followed protocols'.* The complainant said the ASGT's investigation was '*inadequate'* and lacked rigour. The complainant also said the ASGT did not adhere to the relevant guidelines.

My investigation examined the details of the complaint, the Trust's response, and the regional guidelines. I also sought independent professional advice from a qualified social worker. I concluded that the Trust's ASGT investigation into the resident's unexplained fracture, adhered to relevant guidelines. I also concluded that the ASGT made a proportionate and balanced professional judgement to close its investigation based on the analysis of all the available evidence.

However, my investigation also established that the ASGT failed to provide a prompt and timely apology to the complainant in respect of its acknowledgment that the ASGT's Investigating Officer had provided a premature opinion on the investigation's findings. My investigation also established that the ASGT failed to interview the resident's GP as part of its investigation. I considered these failures to constitute maladministration.

I was satisfied that the maladministration identified in this report caused the complainant to experience the injustice of uncertainty about whether input from the GP may have affected the outcome of the ASGT Investigation and frustration.

The investigation did not establish maladministration in respect of the ASGT's adherence of the Regional Adult Safeguarding Policy.

I recommended that the Trust provides the complainant with a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (June 2016), for the injustice caused as a result of the maladministration identified, within **one month** of the date of my Final Report. I further recommended that the Trust reminds relevant staff within its ASGT of the importance of routinely consulting with the GP of vulnerable adults in future investigations, particularly where the GP is actively involved with the adult.

I was pleased to note that the Trust accepted my findings and recommendations.

THE COMPLAINT

1. The complainant raised concerns with this Office on behalf of his late aunt (the resident). The complaint was about the actions of Belfast Health and Social Care Trust (the Trust) and concerned how the Trust's Adult Safeguarding Gateway Team (ASGT)[1] conducted an investigation into an unexplained fracture sustained by the resident on 21 June 2016, while she was resident in a care home. The ASGT closed its investigation on 27 July 2016, on the basis that there was *'no evidence to suggest the Care Home have not acted on care plan or that they have omitted or been neglectful in providing care or have not followed protocols'.* The complainant was dissatisfied with the ASGT's decision to close its investigation and remained concerned that the resident sustained a fracture of her left ankle while she was immobile and bed bound. The complainant said the ASGT's investigation into the cause of the resident's fracture, was '*inadequate'* and lacked rigour. The complainant also said he '*did not believe the Adult Safeguarding Prevention and Protection in Partnership policy was adhered to'*.

Background

2. At the time of the events of this complaint, the resident was ninety-seven years old and was in receipt of nursing care at the Care Home where she had resided since 2 August 2002. She had a medical history of advanced dementia[2], angina[3] and hypertension[4]. She was also bed bound and immobile.

3. On 21 June 2016 the resident was discovered by a Care Home Staff Nurse to have a discoloured and swollen left ankle. Care Home staff contacted the resident's General Practitioner (GP) who advised that she would visit the Care Home after 18:00 on the same day. The Care Home Manager contacted the complainant, who was both the resident's registered 'next of kin' and a GP at the resident's GP practice, to express concern that the resident's ankle may be

[1] The Adult Safeguarding Gateway Team changed its name to Adult Protection Gateway Team in April 2017. However for the purposes of clarity and consistency, the acronym ASGT is used throughout this report.
[2] Advanced dementia features include profound memory deficits, minimal verbal communication, loss of ambulatory activities, the inability to perform activities of daily living, and urinary and fecal incontinence.
[3] Angina - attacks of chest pain caused by reduced blood flow to the heart. The main symptom of angina is a tight, dull or heavy pain in the heart.
[4] Hypertension – high blood pressure, when pressure in blood vessels is unusually high.

broken. On examination by the resident's GP it was noted that the resident's left ankle was swollen, bruised, and misshapen. The resident's GP considered that the ankle appeared to be fractured and recommended the resident be sent to the Emergency department (ED).

4. At 20:00 on 21 June 2016 the resident was transferred by ambulance to the ED at the Royal Victoria Hospital (RVH) where she underwent an x-ray and was diagnosed with a fracture of her left distal tibia and fibula[5]. The resident was admitted to Ward 7B at RVH and was treated with intravenous fluids (IVF), analgesia and had a short leg plaster cast placed on her left calf and foot. She was discharged back to the Care Home on 3 July 2016, with a plan to be reviewed at the Fracture Clinic at RVH two weeks later for a repeat x-ray to be undertaken.

5. The resident attended her review at RVH's Fracture Clinic on 15 July 2016, where, following her cast removal, she presented with a soft tissue infection of her left calf. She was assessed by a Tissue Viability Nurse and documented to have bleeding, a deep pressure ulcer and surrounding cellulitis. She was admitted to Ward 4A at RVH and treated with antibiotics and IVF.

6. While admitted to RVH, the resident's clinical condition deteriorated and on 18 July 2016 her plan of care was changed to palliative with the agreement of her family. The resident sadly passed away on 28 July 2016.

Issue of complaint

7. The issue of complaint accepted for investigation was:
   - **Whether the investigation by the Adult Safeguarding Gateway Team (ASGT) into the resident's fracture was carried out in accordance with the relevant policies and procedures.**

[5] Distal tibia and fibula fracture - a break of the distal tibia or fibula, near or in the 'malleolus (the bony prominence on each side of the human ankle) affecting the tibiotalar (ankle) joint. Occasionally it involves the shaft of the fibula as well.

INVESTIGATION METHODOLOGY

8. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust's comments on the issues the complainant raised.

Independent Professional Advice Sought

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

    - **Qualified Social Worker** – with forty years operational experience delivering health and social care services across all programmes of care in Northern Ireland Health and Social Care Trusts.

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

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

    The general standards are the Ombudsman's Principles[6]:

    - The Principles of Good Administration;
    - The Principles of Good Complaint Handling; and
    - The Public Services Ombudsmen Principles for Remedy

12. The specific standards and guidance referred to are those which applied at the

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

time the events occurred. These governed the exercise of the administrative functions and professional judgement of the Trust staff whose actions are the subject of this complaint.

13. The specific standards and guidance relevant to this complaint are:
    - Regional Adult Protection Policy and Procedural Guidance, Safeguarding Vulnerable Adults, September 2006 (the Safeguarding Vulnerable Adults Policy); and
    - The Department of Health, Social Services and Public Safety and Department of Justice policy document: Adult Safeguarding Prevention and Protection in Partnership, July 2015 (the Regional Adult Safeguarding Policy).

    Relevant sections of the guidance considered are enclosed at Appendix three to this report.

14. In investigating a complaint of maladministration, my role is concerned primarily with an examination of the administrative actions of the Trust to establish that a person was treated in a manner that is fair and consistent with the listed authority's policies and procedures, and in keeping with good administrative practice. It is not my role to question the merits of a discretionary decision taken unless that decision was attended by maladministration.

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

16. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

- **Whether the investigation by the Adult Safeguarding Gateway Team (ASGT) into the resident's fracture was carried out in accordance with the relevant policies and procedures.**

Detail of Complaint

17. The complainant submitted a complaint regarding the ASGT's investigation into an unexplained fracture sustained by the resident on 21 June 2016 while living at the Care Home. The complainant raised concern that the resident sustained a fracture of her ankle while she was immobile and bed bound. The complainant said the ASGT's investigation into the cause of the resident's fracture, was '*inadequate'* and lacked rigour. Specifically, the complainant said that the ASGT did not undertake interviews of Care Home staff and it did not speak to the resident's GP who examined the resident at the Care Home on the evening of 21 June 2016. In addition, the complainant raised concerns that the ASGT did not involve the PSNI in its investigation. The complainant also said he '*did not believe the Adult Safeguarding Prevention and Protection in Partnership policy was adhered to'*.

Evidence Considered

Legislation/Policies/Guidance

18. As part of my investigation enquiries I considered the following policies and guidance:
    - The Safeguarding Vulnerable Adults Policy
    - The Adult Safeguarding Policy.

Relevant extracts of these documents are reproduced at Appendix three to this report.

The Trust's response to investigation enquiries

19. As part of investigation enquiries the Trust was given the opportunity to respond to the complaint. In relation to the issues raised by the complainant,

the Trust stated, '*the [ASGT] adhered to'* the relevant policies. The Trust stated further, '*In the absence of an identified cause (to suggest that [the resident] had been subject to inappropriate practice that may have caused her harm) the APGT [ASGT] determined that there should be a balanced, sensitive and proportionate response in the context of the initial information received*.' The Trust continued, *'It was felt appropriate that the APGT [ASGT] conduct an investigation as 'we could potentially be looking at an allegation against a staff member' as determined by the Designated Adult Protection Officer (DAPO) on duty when considering an appropriate response to the initial information received.'*

20. In relation to the complainant's concern that the ASGT did not undertake interviews of Care Home staff, the Trust said '*As there was no obvious incident reported to the [ASGT] to investigate, it would have been inappropriate to interview staff before a medical opinion was sought as to the possible mechanism of the injury'.*

21. In relation to the complainant's concern that the Care Home Nursing Manager was asked by the ASGT to interview Care Home staff, the Trust said *'There was no direction given to the Nursing Manager that she was to interview staff as part of the [ASGT] investigation, as this would have been outside of her remit. However, it was expected that the Nurse Manager would provide information and a timeline of events to the [ASGT] to form a basis for their investigation.'*

22. In relation to the complainant's concern that the ASGT did not involve the PSNI, the Trust referred this Office to the minutes of a meeting with the Trust and the resident's family on 29 July 2016, where *'this issue was discussed in length'*. The Trust said, '*Clarification and a rationale for decision making was provided outlining that if, in assessing the injury, the [ASGT] were advised or suspected that neglect had been caused to [the resident] by the [Care] Home, [ASGT] would have made a referral to the PSNI police and formal interviews with staff at the stage conducted'.*

23. In relation to the complainant's concern that the resident's GP was not spoken

to as part of the ASGT investigation, the Trust said '*The APGT [ASGT] continue to believe that the opinion on the causation of [the resident's] fracture required to be sought from the most appropriate medical/surgical practitioner dealing [with] her care at that time, this being [the Consultant Orthopaedic Surgeon] at RVH.*

Relevant Records

24. I obtained and examined the resident's records from the Care Home and the records of the ASGT investigation. The extracts which I considered to be of particular relevance to my investigation are included at Appendix four to this report.

Relevant Independent Professional Advice (IPA)

25. The IPA was asked whether the ASGT's investigation strategy and method of investigation were reasonable and appropriate. In response, the IPA advised, *'The strategy undertaken by the ASGT for the investigation, was focused on collating relevant clinical expert opinion on the possible causation of the fracture; collating appropriate care records in the hospital and care home settings to ensure that there was evidence that the agreed care plan was being delivered prior to the injury; assess the openness of the care home in respect of cooperating with the investigation; liasing [sic] with RQIA as regulator and inspection agency as to whether there were any trends or findings from inspection visits that required to be taken into consideration regarding the leadership , workforce and operational practice in the care home that may be significant regarding safeguarding.'*

26. The IPA continued, '*There is evidence in the documentation and minutes of strategy and review meetings that the ASGT took into consideration a range of indicators of quality in regards to staffing rotas and whether the patient's care plan was adhered to. The strategy also focused on whether there was a need for an immediate protection plan.'*

27. The IPA advised further, '*It is my professional opinion that the overall investigation strategy and the method of investigation undertaken by the ASGT*

in this case was reasonable and appropriate and in accordance with [the] regional safeguarding policy "Prevention and Protection in Partnership" 2015'. In support of her view, the IPA provided a detailed rationale in relation to each aspect of the ASGT investigation, available in her full IPA report at Appendix five to this report.

28. In relation to the complainant's concern that the DAPO did not speak to him during the ASGT investigation, the IPA advised, *'the role of the DAPO is to manage the referral and ensure that appropriate actions are taken.'* The IPA continued, *'Those actions include lia[i]sing with and providing feedback to referrers and NOK [next of kin]. The policy does not state that the DAPO is required to directly contact the NOK and in this case this function was appropriately delegated to the Investigating Officer. It is my professional view that this was appropriate and in accordance with the policy guidance'.*

29. In relation to the training and competence of the appointed DAPO and Investigating Officer (IO), the IPA advised, '*both had the appropriate training and experience to fulfil the role. The DAPO was a registered social worker and the IO was a qualified nurse specialist with the skills and experience necessary to review the care home nursing records, positioning, wound charts and staff rotas and allocation'.*

30. Enquiries were made of the IPA as to the complainant's concern that the ASGT investigation did not seek to interview the resident's GP and whether this was appropriate. In response the IPA advised*, 'Whilst the ASGT had identified that the most relevant medi[c]al opinion was the Orthopaedic Consultant, I would have considered it to be relevant for the IO to contact the GP to ascertain their opinion of the care home response and to identify if there were any trends/ previous issues or concerns that should be taken into consideration'.* The IPA advised further*, 'The IO had access to and did review the GP record as part of the hospital records, therefore it is unlikely that further clinical information on the incident was missed'.* The IPA continued, *'however this was a missed opportunity to gather opinion from the wider range of services involved with the patient and I would recommend that investigations should include consultation*

with patient's GP if they are actively involved with the patient. This is a learning point…'

31. The IPA was referred to the minute of the Trust's Family meeting held with the complainant dated 29 July 2016. It was pointed out to the IPA that the Trust stated '*ASGT would not routinely interview staff if they were not required to do so and on this occasion the ASGT were satisfied with the information provided by the [Care Home] Manager'*. The IPA was asked whether she considered it appropriate and reasonable that the ASGT did not interview the Care Home staff as part of its investigation. In response, the IPA advised '*The Investigation strategy in this case was to obtain expert clinical opinion in regards to causation of the injury and pending clinical opinion from the Orthopaedic Consultant, collate and analyse all relevant documentation relating to the care of the resident in the care home. The I.O. visited the home and reviewed all documentation relating to patient care and risk management. During the visit the I.O. took the opportunity to speak to the nurse who dressed the patient's toe the day before the injury was noted and the nurse manager. The care home nurse manager was asked to collate and provide care documents but was not asked by the DO or IO to interview care home staff. The I.O. reviewed a number of quality indicators and did not just relay [sic] on the care records provided by the care home'.*

32. The IPA advised further, '*It is my professional view that visiting the care home and analysing the range of care documents provided by the care home and hospital, provided the I.O. with an independent overview of the care records and whether the care home had adhered to the patient's care plan or whether there was any evidence of neglect or omission of care. This informed the professional judgement as to whether there was a need to interview the care home staff.'*

33. In relation to this issue, the IPA concluded her advice, '*that it was reasonable and appropriate that the ASGT investigation did not require the I.O. to interview care home staff at this stage of the protection process as the focus was on fact finding and obtaining expert clinical advice to determine if any additional actions*

may be required'.

34. The IPA was referred again to the minute of the Trust's Family meeting with the complainant dated 29 July 2016 in which the Trust stated, '*if, in assessing the injury, ASGT were advised that neglect was caused to [sic] by the [Care] Home… a referral to police would have been made and formal interviews with staff conducted'.* Enquiries were made of the IPA as to whether it was appropriate and reasonable that the ASGT did not involve the PSNI in its investigation. In response, the IPA advised, '*In keeping with the regional safeguarding policy the ASGT made a professional judgement based on expert medical advice and the evidence available from the investigation as to whether there was evidence of neglect or omission of care. It is understandable that this professional judgement is challenging and difficult for the resident's family who are seeking a definitive explanation for the fracture… however in my professional opinion… the advice provided by the Trust at the family meeting on 29 July 2016... [was] a reasonable and appropriate explanation in this case'.*

35. The IPA advised further, *'The regional policy states that HSC Trusts will be the lead in terms of the coordination of joint adult protection responses and where a criminal act is either alleged or suspected a report must be made to the PSNI.'* However, the IPA continued, '*This is predicated on the assessment / investigation phase [of an ASGT investigation] identifying if a criminal act is suspected when all relevant information is analysed and coordinated'.*

36. The IPA continued, *'The policy highlights that the exercise of skilled competent assessment by HSC professionals in the determination of the appropriate response is crucial in the context of providing a proportionate, balanced; rights based response to the presenting issues of risk in the context of the unique circumstances of individual adults. In this specific case, the ASGT investigation acknowledged that the patient had sustained a fracture and that the definition of harm was met, however the application of professional judgement having considered all of the available evidence and expert clinical opinion did not find evidence that abuse, neglect or omission of care had occurred'.*

37. The IPA was asked whether, in her professional opinion, the ASGT ought to

have involved the PSNI in this case. In response, the IPA *advised 'I view the actions taken by the ASGT in not involving the PSNI as proportionate and based on the outcome of balanced decision making having analysed all of the expert clinical advice and information available'.* The IPA advised further, *'At referral screening stage, the ASGT had acknowledged the potential for a member of staff to have caused the injury but following the Safeguarding investigation in this case, the A[SGT] found no evidence that a crime was suspected'.* She reiterated her advice that *'It is my professional opinion that the decision taken not to involve the PSNI was proportionate and taken in accordance with regional safeguarding policy'.*

38. The IPA was asked whether she considered it appropriate in the circumstances of this case, that the ASGT investigation involved information gathering by the Care Home Manager. In response, the IPA advised *'At all stages of the protection process, there is a need for basic fact finding and I view the information gathered by the care home manager as an appropriate part of the investigation process. In addition the I.O. visited the care home and independently reviewed all records which provided additional assurance'.*

39. In explaining her view, the IPA referred to the *'learning arising from independent investigations into the quality of care in care homes such as the Commissioner for Older People for Northern Ireland (COPNI) "Home Truths" report (June 2018) and the DOH Audit of Safeguarding referrals in care homes (2019)'.* In doing so the IPA explained, '*The DOH audit highlights evidence of the marginalisation of involving care home professionals whose roles were too frequently limited to reporting incidents to trusts. The audit found that not enough credence is given to basic fact finding by care homes. The resident had lived in the care home for fourteen years and the care home therefore will have significant information and knowledge of the needs and risks for the resident'.*

40. The IPA advised further, '*The action taken by the ASGT was in keeping with basic fact finding and did not include asking the care home to interview care home staff on behalf of the ASGT. The information provided by the care home was not used in isolation and provided the context and understanding of the resident's social circumstances and daily living requirements in line with*

regional policy requirements…. it is my professional opinion that the explanation provided by the trust in meeting with the family on 29/7/16 was appropriate and reasonable'.

41. It was pointed out to the IPA that the ASGT closed its investigation following receipt of the medical opinion from the Consultant Orthopaedic Surgeon. Enquiries were made of the IPA as to the appropriateness of the decision to close the investigation on this apparent basis, and whether to do so was in line with relevant policies. In response, the IPA pointed out in her advice that '*There is evidence in the documentation… that the ASGT decision was not based solely on the expert medical opinion from the consultant orthopaedic surgeon, but took into consideration the daily living records and whether appropriate care and support and individualised care plan had been in place and adhered to in the care home prior to the injury to judge whether there was any evidence of neglect or omission of care'.*

42. The IPA continued, '*The ASGT liased [sic] with RQIA to clarify whether there were any concerns noted through RQIA inspections or monitoring of incidents and complaints within the care home that the ASGT needed to take into consideration when assessing the potential that a staff member had caused the injury by neglect or omission of care'*. The IPA advised, '*There is therefore evidence that the ASGT assessed whether there was evidence of neglect or omission of care by the care home and did not rely solely only on the medical opinion regarding possible causation. Whilst the expert medical opinion relied on by the ASGT in regards to possible cause and decision to close the ASGT investigation was from the most appropriate consultant orthopaedic surgeon, there was consistency of medical opinion across a range of medical staff… All report that the mechanism of injury is unknown, there was no obvious history of trauma but all report a history of poor bone quality due to Osteoporosis'.*

43. The IPA also advised, '*The regional safeguarding policy highlights that it is not possible to definitely state when an adult is at risk of harm as this will vary on a case by case basis. The definitions provided in the regional policy are meant to provide guidance as to when an adult may be at risk of harm, in order that further professional judgement can be sought but there are no absolute criteria*

for judging when harm has become serious harm. This is an important issue given that the NOK challenged the assertion of the IO that the incident does not constitute neglect as defined in the adult safeguarding procedure. The NOK also referred to the Adult safeguarding information sheet provided to GPs which explicitly refers to unexplained fracture as a possible sign of physical abuse or harm.'

44. The IPA advised further, *'The ASGT did assess the referral as level three due to the potential that a member of staff may have caused the injury which evidences ASGT awareness that an unexplained fracture may be a possible sign of abuse requiring a protection investigation. The regional policy highlights however that harm does not always mean abuse. The Consultant Orthopaedic medical opinion and the clinical opinion of the tissue viability nurse were not taken in isolation, but set in the context of the patient's social circumstances and daily living requirements to inform professional judgement in relation to case closure… this is in keeping with the regional policy'.*

45. The IPA pointed out in her advice, that while the minutes of the Trust Strategy Review meeting held on 27 July 2016, *'conclude that the case is closed based on the Consultant Orthopaedic clinical opinion… the Investigation had also investigated whether there was evidence of neglect or omission of care by the care home and had relied on the review and analysis of care home records to evidence the [IO's] findings in this regard'*. The IPA advised, *'It would [have been] appropriate in reaching a decision to close an investigation to record all evidence relied on and not just the expert medical opinion'.*

46. In relation to the ASGT's decision to close the investigation, the IPA concluded that '*It is my professional opinion that the ASGT made a balanced, proportionate and considered judgement based on all the available evidence. The expert medical opinion provided immediately before the Review strategy meeting on 27/6/16 provided the outstanding expert medical advice that the ASGT required to conclude the investigation. The review strategy meeting minutes, evidence that the ASGT took the social circumstances, the environment within the care home and the direct care provided to the resident in the care home into consideration as well as the expert medical opinion. In my*

professional opinion, the ASGT acted in accordance with what would reasonably be expected in similar ASGT investigations and in accordance with regional safeguarding policy'.

47. The IPA was asked whether, overall, she considered the investigation by the ASGT in this case was undertaken in accordance with the relevant policies. In response, the IPA advised, '*The regional Policy places a requirement on the ASGT to make a proportionate and balance[d] professional judgement based on analysis of all the evidence available…it is my professional opinion that the ASGT made a proportionate and balanced judgement in this case and that the investigation was carried out in accordance with the relevant policies and procedures'.*

48. The IPA concluded her advice by recommending a number of learning and service improvements for the Trust. These are explained in full in the IPA's report at appendix five. They include:

- *'The ASGT should review the learning from this complaint to consider how families can be more actively involved with view to building confidence in the adult protection investigation process. Throughout the ASGT investigation the family should be updated regularly and in line with updated evidence and the family's concerns;*
- *The Trust ASGT should seek to consult the GP routinely in any future ASGT investigation;*
- *The Trust ASGT should review the learning from this complaint in regards to accurate recording of Strategy meeting decisions to close an investigation to ensure that the summary decision reflects all of the evidence relied on to make the decision; and*

  In the event that delay is due to the range of clinicians involved, the Trust should ensure that the family are clear about who the ASGT view as the most appropriate clinician to provide expert opinion as this may differ from the responsible consultant for the in-patient'.

Trust's response to the draft report

49. The draft copy of this report was shared with the Trust for its comment. In response, the Trust confirmed that it accepts the report's analysis and findings. The Trust also said it '*wishes to commit to learning from this complaint and [that] a learning and reflective session will be carried out with the ASGT team.'* In addition, the Trust said '*it is the intention of the Trust to ensure that the learning from this report is shared across other teams who are involved in Adult Safeguarding Investigations'.*

Complainant's response to the draft report

50. The draft copy of this report was shared also with the complainant. In response, the complainant said he had *'no comments on the content of the report'* and that he '*did not wish to comment on the findings and conclusions'.* The complainant also said he was '*content that the evidence set out in the report is factually correct'.*

Analysis and Findings

Failure to interview Care Home Staff

51. In submitting his complaint to this Office, the complainant raised concerns that *'there was [sic] no independent interviews of staff'* undertaken as part of the ASGT investigation. As part of my consideration of this issue I referred to the relevant policies and procedures. I note that they do not prescribe the precise process which ought to be undertaken during an adult protection investigation. I note rather, that 11.1 of the Regional Adult Safeguarding Policy provides that *'each adult protection intervention is likely to be unique and the response made must allow for flexibility and individualised decision-making'*. The Policy states further, *'At all stages throughout the adult protection intervention, consideration should be given to whether the threshold for the Adult Protection... Service continues to be met'*.

52. In this regard, I considered the investigation strategy undertaken by the ASGT in this case, which the IPA advised, '*was to obtain expert clinical opinion in regards to causation of the [resident's] injury and pending clinical opinion from the Orthopaedic Consultant, collate and analyse all relevant documentation*

relating to the care of the resident at the Care Home'. I accept IPA's advice that this strategy and the ASGT's method of investigation were *'reasonable'*, *'appropriate*' and '*in accordance with the Regional [Adult] Safeguarding Policy'.*

53. On examination of the relevant records, I note the IO visited the Care Home on 24 June 2016 and reviewed documentation relating to the resident's care and risk management. This included the resident's care plans, repositioning charts, wound chart and photographs of the area affected, as well as staff rotas, staff allocation and daily living records. The relevant records indicate that the IO also spoke to both the Nurse Manager and the nurse who dressed the resident's toe on the day before the injury was noted. On examination of the relevant records I note there was no documented record of any event noted by staff in the care home records that indicated an injury to the resident or its cause.

54. I note the IPA pointed out in her advice, that the '*care home was fully cooperative'* with the ASGT investigation and made all relevant records available to the IO for analysis. Having reviewed the available evidence, I accept the IPA's advice. I note the IPA also advised, *'that at an individual case level, recording supports good practice and gives evi[de]nce that the practitioner and the organisation are meeting the expected standards of service'.* In this regard, I accept that the IPA was satisfied that the IO's review of the care home records '*provided evidence of appropriate recording and adherence to [the resident's] care plan and adherence to professional and regulatory standards'*.

55. Moreover, I accept the advice of the IPA that by visiting the Care Home and undertaking an independent analysis of the resident's care records, this *'provided the IO with an overview of… whether the Care Home had adhered to the [resident's] care plan or whether there was any evidence of neglect or omission of care'.* I accept further, the IPA's advice that '*This informed the professional judgement as to whether there was a need to interview the care home staff'.* I note the IPA advised that it was both *'reasona*ble' and '*appropriate'* that the ASGT investigation did not require the IO to interview the Care Home Staff. The IPA explained this is because the focus at this stage in

the protection process '*was on fact finding and obtaining expert clinical advice to determine if any additional actions may be required'*. I accept the IPA's advice in this regard.

56. Having examined the available evidence, I found no evidence to support the complainant's concerns that the ASGT failed to adhere to the Regional Adult Safeguarding Policy in respect of its decision not to interview Care Home Staff. Thus I do not uphold this element of the complaint.

Information gathering by Care Home Staff

57. In submitting his complaint to this Office, the complainant also raised concerns that the ASGT investigation involved information gathering by Care Home Staff. I note in particular, the complainant's concerns that the Care Home's Nurse Manager was asked to interview staff on the ASGT's behalf. In response to investigation enquiries in relation to this element of the complaint, I note the Trust said '*There was no direction given to the Nursing Manager that she was to interview staff… however, it was expected that [she] would provide information and a timeline of events to the [ASGT] to form a basis for their investigation'.* Having examined the relevant records I note that the Care Home Nurse Manager was asked to collate and provide care home documents for the purposes of the IO's review and analysis. However, I found no evidence to indicate that the Nurse Manager was asked by the ASGT to interview Care Home staff. I note the IPA concurred with this view and advised that '*The action taken by the ASGT was in keeping with basic fact finding'.* However, the IPA advised it *'did not include asking the care home to interview care home staff on behalf of the ASGT'.*

58. In considering the appropriateness of information gathering by Care Home staff for the purposes of the ASGT investigation, I had due regard to both the advice of the IPA and the regional safeguarding guidance. I am satisfied that pursuant to the Regional Adult Safeguarding Policy, information gathering and basic fact finding are integral to all stages of the protection process. I note also 13.4 of the Safeguarding Vulnerable Adults Policy which provides that an investigation should be informed by information gained by '*those who have knowledge of the*

person and his or her circumstances'. I note that at the time of sustaining her injury, the resident had lived in the Care Home for fourteen years and thus I accept the IPA's advice that staff would have had *'significant information of the [resident's] needs and risks'*. I therefore consider it reasonable and appropriate that Care Home Staff collated information for the purposes of the ASGT's investigation. Moreover, as stated above (paragraph 50 refers), in line with the ASGT's investigation strategy which focused on fact finding and in the absence of any evidence to indicate neglect or omission of care, I consider it both appropriate and reasonable that this information was not sought via formal interviews.

59. Furthermore, I note the IPA advised that the information provided by the Care Home '*was not used in isolation'* but '*provided the context and understanding of the resident's social circumstances and daily living arrangements in line with regional policy requirements'*. The IPA advised further that the IO's visit to the Care Home and his independent analysis of all records '*provided additional assurance'* as to the veracity of the information provided. Having examined the relevant records, I accept the IPA's advice in this regard and that the information gathered by the Care Home Manager was both '*an appropriate part of the investigation process and 'reasonable'*. I do not therefore uphold this element of the complaint.

The resident's history of falls

60. In submitting his complaint to this Office the complainant raised concerns that that the ASGT Investigation Report provided an inaccurate history of the resident's previous falls. Having reviewed the available documentation I note the Investigation Report refers to information provided by the Care Home Nurse Manager during a Strategy meeting with the DAPO and IO on 18 July 2016. Having reviewed the minutes of this meeting, I note the Nurse Manager referred to three previous fractures sustained by the resident while living in the Care Home. These fractures included the resident's right arm in 2008, her right foot in July 2010 and her right heel in August 2010. In reference to the Care Home's report of these fractures, the meeting minutes state *'There had been no suggestion of a fall in any of the above incidents'*. I note in his complaint to the

Trust dated 6 February 2017, the complainant disagreed with this statement and said that the resident had had a fall in 2008 and 2010. I note the Trust, in its response to the complainant dated 5 June 2017, said '*the previous falls had been unrelated to this episode. As such the ASG Investigation Team were investigating the possible cause of a fracture while [the resident] had been immobile*'.

61. In considering this element of the complaint, I consider the reference to previous fractures made in the report reflected the information reported by the Care Home. However, I am satisfied that the ASGT investigation related to the resident's injury sustained on 21 June 2016 while she was bed bound. Having examined the available records, in particular, the minute of Care Management Resident Review completed on 23 July 2015, I note that the resident was documented as being bed bound for up to one year prior to 21 June 2016. I am satisfied that consideration of falls on this occasion sustained by the resident before she became bed bound was not required or relevant to the issue under investigation. Consequently, I do not consider the statement relating to previous falls, affected the ASGT's investigation into the resident's unexplained injury sustained on 21 June 2016. Furthermore, I accept that the IPA was satisfied that *'there was evidence that care home records were personally screened by the IO to provide assurance that [the resident's] care plan had been followed and to determine if there was any evidence of neglect or omission of care'*. Accordingly, I do not consider the ASGT failed to adhere to the relevant policies in respect of this issue raised by the complainant. While accepting that the complainant would have a clear recollection of the circumstances that led to the previous fractures I am satisfied that the resident's circumstances had changed, I therefore do not uphold this element of the complaint.

Failure to interview the resident's GP

62. I note the complainant was dissatisfied that the ASGT investigation did not involve interviewing the resident's GP. I note the resident's GP attended the Care Home on the evening of 21 June 2016, the day the resident's injury was noted and on suspecting it may be fractured, arranged for the resident to attend the ED. As previously discussed, I am satisfied that the regional safeguarding

guidance does not prescribe the precise process which ought to be undertaken during an adult protection investigation. Nor does it stipulate the individuals whom the ASGT ought to interview during an investigation. Rather, I am satisfied that the guidance highlights that the adult safeguarding response ought to allow for flexibility and individualised decision-making.

63. I note in response to this element of the complaint, the Trust said the ASGT did not seek to speak to the resident's GP as part of its investigation. The Trust explained that the resident's GP was not interviewed during the investigation as the ASGT considered *'that the opinion on the causation of [the resident's] fracture required to be sought from the most appropriate medical / surgical practitioner dealing [with] her care at that time this being [the Consultant Orthopaedic Surgeon] at RVH'.* I note the IPA's advice in which she agreed that the ASGT '*appropriately identified that the most relevant medical opinion'* as to the causation of the resident's fracture was that of the Orthopaedic Surgeon. Notwithstanding, I note the IPA also advised that she '*would recommend that adult safeguarding investigations should include consultation with [a] patient's GP if they are actively involved with the patient'*.

64. I note in particular, the IPA's advice that she considered it '*to be relevant for the IO [in this case] to contact the GP to ascertain their opinion of the care home response and to identify if there were any trends / previous issues or concerns that should be taken into consideration'*. I note the IPA further advised that in failing to do so, *'this was a missed opportunity to gather opinion from a wider range of sources'*. I accept the IPA's advice in this regard. I consider that '*it would have been good practice'* for the ASGT to have interviewed the resident's GP in this case, in particular as the GP had examined the resident on the evening of 21 June 2016, the day when the injury was noted. Thus in my view, the ASGT's failure to interview the resident's GP as part of its investigation, constitutes a failure. I thereby uphold this element of the complaint.

65. I considered whether the ASGT's investigation was adversely impacted as a result of this failure. I note the IPA pointed out that '*The IO had access to and*

did review the GP records [sic][7] as part of the [resident's] hospital records, therefore it is unlikely that further clinical information on the incident was missed'. I accept the IPA's advice in this regard. I do not consider the ASGT's failure to interview the resident's GP significantly impacted its investigation. I am satisfied that the IPA advised that the investigation / assessment stage of the adult protection process which was undertaken by the ASGT '*adhered to the regional policy'* and that the method of investigation was '*reasonable and appropriate'.* However, I consider the complainant experienced the injustice of uncertainty about whether input from the GP may have affected the outcome of the ASGT Investigation.

Failure to involve the PSNI

66. I note the complainant was dissatisfied that the PSNI was not involved in the ASGT investigation. As part of my consideration of this element of the complaint I referred to the Safeguarding Vulnerable Adults Policy. 13.7 (c) of which provides that *'detailed consideration of the need for a joint investigation with the PSNI will be triggered when there is allegation or suspicion that… a criminal offence has been committed against a vulnerable adult'. This includes 'physical abuse of ill-treatment amounting to a criminal offence'*. Pursuant to this policy, I am satisfied that a report must be made to the PSNI where a criminal act is suspected or alleged. However, I accept the IPA's advice that this *'is predicated on the ASGT's assessment/investigation phase identifying if a criminal act is suspected when all relevant information is analysed and coordinated'*.

67. I considered also the Trust's response to this element of the complaint, in which it said that '*if, in assessing the injury, the [ASGT] were [sic] advised or suspected that neglect had been caused to [the resident] by the [Care] Home [ASGT] would have made a referral to the PSNI police and formal interviews with staff at the stage conducted'.* Having examined the available evidence, I accept the IPA's advice that the referral to ASGT was '*appropriately'* screened at level 3 due to the possibility that a member of Care Home staff may have

[7] This should read 'report' in reference to the GP's report on her Care Home visit on 21 June 2016.

caused injury through neglect or omission of care. However, I accept the IPA's advice that *'the application of professional judgement having considered all of the available evidence and expert clinical opinion did not find evidence that abuse, neglect or omission of care had occurred.'* I accept the IPA's advice that in making this determination, the ASGT was in '*keeping with the regional [adult] safeguarding policy'* and *'made a professional judgement based on expert medical advice and the evidence available from the investigation as to whether there was evidence of neglect of omission of care'*.

68. Therefore, having considered the available evidence, the relevant policies and the considered advice of the IPA, I am satisfied that the Trust's response to this element of the complaint as to why the PSNI were not involved in the ASGT's investigation, was both reasonable and appropriate. I am satisfied further that the ASGT's actions in this regard were in line with the regional safeguarding guidance. I note the IPA concurs with this view. I do not therefore uphold this element of the complaint.

Premature opinion given by IO

69. I note the complainant's concern that upon speaking to the ASGT's IO on 1 July 2016, the IO expressed a premature opinion that the resident's injury was deemed '*not malicious or caused by neglect'*. The available documentation indicates that the IO telephoned the complainant on 30 June 2016 to provide an update on the investigation. Having reviewed the documented record of this telephone call I note it states that the complainant was informed that *'on review of the notes and speaking to relevant others there, at the moment, is no evidence of malicious intent or negligence'*. As part of my consideration of this element of the complaint I also examined the Trust's response to the complainant in respect of this issue. I note the Trust accepted that in speaking to the complainant on 1 July 2016[8], the IO did communicate a premature opinion regarding the findings of the ASGT's investigation. Having examined the record of the Trust's meeting with the complainant on 29 July 2016, I note

[8] While both the complainant and Trust refer to this telephone call as having taken place on 1 July 2016, the records indicate it occurred on 30 June 2016. Notwithstanding, reference is made to 1 July 2016 in keeping with the date cited in the both the Trust and complainant's correspondence.

the Trust acknowledged that at the time of speaking to the complainant on 1 July 2016, the IO had insufficient information to reach a conclusion about the ASGT's investigation outcome.

70. I also note the Trust, in its letter to the complainant dated 5 September 2016, acknowledged to the complainant that the information communicated to him by the IO on 1 July 2016, '*would have caused him undue confusion and concern in terms of his understanding and confidence in the Trust's adult safeguarding role and the remit of the investigation process'*. I consider it good practice that the Trust was open and transparent in concurring with the complainant's view that the IO was premature in anticipating the outcome of the investigation in this instance.

71. In addition, I welcome the actions taken by the Trust in response to this issue. These actions included raising the issues of communication and information sharing with its safeguarding team at a staff meeting and amending the roles and responsibilities of designated DAPOs and IOs[9] in relation to investigations. I note that the Trust said that this incident was also addressed with the relevant IO during formal supervision and that he has undertaken relevant reflective work on communication.

72. The Third Principle of Good Administration, *'being open and accountable'* requires bodies to be '*open and clear about policies and procedures'* and ensure *'that information, and any advice provided, is clear, accurate and complete'*. The Trust accepted that in speaking to the complainant on 1 July 2016, the information provided by the IO was misleading in its suggestion that there was no evidence of neglect or omission of care before the investigation had completed. I consider the failure to provide accurate and clear information in this instance constitutes a failure.

73. Thus, notwithstanding the actions taken by the Trust (paragraph 69 refers), I considered the impact this failure had on the complainant. In my view this

[9] The roles of designated DAPO and IOs were amended so that IOs will abdicate responsibility for weekly updates to the DAPO in instances where complex issues are identified with the vulnerable adult or NOK during the liaison process.

incident caused the complainant to experience the injustice of uncertainty as to the rigour of the ASGT investigation and whether there was predetermination prior to the full consideration of all the evidence by relevant staff.

74. The fifth Principle of Good Administration, *'putting things right*' requires bodies to *'acknowledge mistakes and apologise where appropriate'* and to ensure they provide '*prompt, appropriate and proportionate remedies'*. Furthermore, I consider the provision of fair and proportionate remedies is an integral part of good complaint handling. I consider that in this instance, the Trust was prompt to acknowledge its mistake. I also consider that an apology was an appropriate remedy, and the Trust ought to have apologised to the complainant in a timely manner. I reviewed the record of the Trust's meeting with the complainant of 29 July 2016, and the Trust's subsequent letters to the complainant during its complaints process. In doing so, I note that the Trust did not provide a prompt apology to the complainant in response to its acknowledgement that the IO expressed a premature opinion of the ASGT's investigation findings. Instead, I note the Trust's letter to the complainant dated 5 June 2017 in which it said it was *'extremely sorry that you have been left feeling disappointed with… staff's communication with you'.* I consider an apology from the Trust to be an appropriate remedy in this instance. However, I am critical of the timeliness of this apology. I consider it ought to have been made when the Trust first accepted that this incident had occurred. In my view, the Trust's delay in providing its apology constitutes maladministration. I consider this would have caused the complainant to experience frustration. As a result, I uphold this element of the complaint.

Overall adherence to relevant policies

75. The complainant raised concerns that the ASGT investigation did not adhere to the Regional Adult Safeguarding Policy in respect of the issues discussed above. However, in light of the available evidence and based on the considered advice of the IPA, I found no evidence to support these concerns. I acknowledge and understand the concern caused to the complainant and his family that the resident could sustain a fracture without explanation. I also understand that the complainant is keen to have a definitive cause for the

resident's injury.

76. However, I accept the IPA's advice that the Regional Adult Safeguarding Policy places a requirement on the ASGT to make a proportionate and balanced professional judgement based on analysis of all the evidence available. In this case, I am satisfied that the expert medical opinion from the Consultant Orthopaedic Surgeon highlighted that the resident was vulnerable due to very poor bone quality, such that he advised that the injury could have been caused by minimal forces, which *'would not have normally cause injury'* to someone with good bone quality. Furthermore, having reviewed the relevant records including the medical opinion of the Consultant Orthopaedic Surgeon and the SHO, I note there was consistency of opinion that the mechanism of the resident's injury was unknown, there was no obvious history of trauma and that the resident had a history of poor bone quality due to osteoporosis. Having examined the available records, I accept the IPA's advice that the ASGT did not consider this expert medical opinion in isolation. Rather, the IPA advised that the ASGT '*took into consideration a range of quality indicators'* including…*'the resident's social circumstances and whether the Care Home had adhered to the resident's care plan'* in order to inform its professional judgement in relation to case closure. I accept the IPA's advice that she was satisfied that in doing so, the '*ASGT… found no evidence of neglect or omission of care by the Care Home'*.

77. Overall, I accept the IPA's advice that the ASGT '*made a proportionate and balanced judgement in this case and that the investigation was carried out in accordance with the relevant policies and procedures*'. I do hope the complainant is reassured by this advice. As a result and for the reasons outlined above, I do not uphold this element of the complaint.

Recording of reasons for case closure

78. On examination of the Strategy Review meeting minutes I note that they conclude that the '*ASGT is closing the case based on Orthopaedic Consultants [sic] opinion of injury'.* I am satisfied that this meeting minute does not reflect all of the evidence relied on by the ASGT to inform its decision to close the case.

Having reviewed the available records, I accept the IPA's advice that the ASGT had also '*investigated whether there was evidence of neglect or omission of care by the care home and had relied on the review and analysis of care home records to evidence the IO's findings in this regard*.' In addition, the IPA advised *'the IO reviewed a number of quality indicators and did not just relay [sic] on the care records provided by the care home'.* The IPA was satisfied that the decision to close the investigation was thus not based on the Orthopaedic Surgeon's medical opinion in isolation, but that the review of '*a range of quality indicators'* informed the ASGT's professional judgement. I accept the advice of the IPA *that 'it would be appropriate in reaching a decision to close an investigation to record all evidence relied on and not just the expert medical opinion'.* I am satisfied however, that the information considered by the ASGT was outlined in the Investigation Report which was provided to the complainant. Notwithstanding, I consider the Trust may wish to reflect on the learning identified by the IPA in respect of recording minutes of Strategy Review meetings to ensure its reasoning for case closure decisions is recorded appropriately, accurately and fully.

CONCLUSION

79. I received a complaint about the Trust's ASGT's investigation into an unexplained fracture sustained by the resident at the Care Home on 21 June 2016. The complainant said the ASGT investigation was '*inadequate'* and that he *'had lost faith in the ability of ASGT to rigorously investigate such incidents'*. The complainant also said that the ASGT failed to adhere to the Regional Adult Safeguarding Policy.

80. The investigation established that the ASGT's investigation into the injury sustained by the resident, adhered to the relevant guidelines. In addition to obtaining expert medical opinion as to the cause of the resident's injury, I found that the ASGT appropriately considered a number of quality indicators as part of its investigation. I am satisfied that in doing so, the ASGT found no evidence of neglect or omission of care by the Care Home. The investigation established that the ASGT made a proportionate and balanced professional judgement to

close the investigation based on its analysis of all the evidence available.

81. However, the investigation established that the Trust failed to provide a prompt and timely apology to the complainant in respect of its acknowledgment that the ASGT's IO had provided a premature opinion on the investigation's findings. The investigation also established that the ASGT failed to interview the resident's GP as part of its investigation. I considered these failures constitute maladministration.

82. I am satisfied that the maladministration identified in this report caused the complainant to experience the injustice of frustration, and uncertainty about whether input from the GP may have affected the outcome of the ASGT Investigation.

83. The investigation did not establish maladministration in respect of the ASGT's adherence to the Regional Adult Safeguarding Policy. I note also the investigation did not establish the cause of the injury to the resident. The complainant's desire for a full and detailed investigation to ensure the protection of vulnerable adults in care settings is what society would expect from the Trust's safeguarding process. In this case, while there were issues identified with the Trust's process as outlined above, I am satisfied that the ASGT's decision to close the investigation without a definitive cause for the injury or referral to the PSNI was reasonable. I am however, in no doubt as to the distress that this would have caused the complainant and the resident's wider family.

Recommendations

84. I recommend that the Trust provides the complainant with a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (June 2016), for the injustice caused as a result of the maladministration identified, within **one month** of the date of my Final Report.

85. I further recommend that the Trust reminds relevant staff within its ASGT of the importance of routinely consulting with the GP of vulnerable adults in future investigations, particularly where the GP is actively involved with the adult.

86. The Trust may wish to reflect on the IPA's recommendations for learning and improved service as outlined in paragraphs 48 and 78.

I am pleased to note that the Trust accepted my findings and recommendations.

MARGARET KELLY
Ombudsman **February 2021**

Appendix One

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.

Appendix Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

- Publishing service standards for handling complaints.

- Providing honest evidence-based explanations and giving reasons for decisions.

- Keeping full and accurate records.

4. Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.

- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.

- Ensuring that decisions and actions are proportionate, appropriate and fair.

- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.

- Acting fairly towards staff complained about as well as towards complainants

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.

- Providing prompt, appropriate and proportionate remedies.

- Considering all the relevant factors of the case when offering remedies.

- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

6. Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.

- Having systems in place to record, analyse and report on learning from complaints.

- Regularly reviewing the lessons to be learnt from complaints.

- Where appropriate, telling the complainant about the lessons learnt and the changes made to services, guidance or policy.