Investigation of a complaint against Belfast Health and Social Care Trust

Report Reference: 202002606

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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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Listed Authority: Belfast Health and Social Care Trust

SUMMARY

I received a complaint about the actions of the Belfast Health and Social Care Trust (the Trust). The complainant raised concerns about the Trust's assessment of his suitability as a kinship carer for his grandchildren. I found significant instances of maladministration in how both the assessment and investigation of the complaint were managed.

The complainant said the Social Work Team used false accusations to prevent his application to take up the role of kinship of his grandchildren. The complaint was partially upheld.

The complainant's grandchildren were taken into care on 24 February 2021 and on that day the Social Work Team contacted the Police Service of Northern Ireland (PSNI) to undertake an initial check on the suitability of the complainant as a kinship carer. On the basis of this information the complainant was told he was unsuitable to provide care at this point. The complainant challenged the accuracy of the information and gave his permission for a full criminal record check.

The investigation established that on the balance of probabilities the Social Work Team did contact the PSNI by telephone on 24 February 2021. However as there was no record of the conversation this could not be verified. It also became clear that the information conveyed or understood on that day was inaccurate. I found this was maladministration.

The investigation established the Social Work Team appropriately responded on the day of the children's removal (24 February 2021) to the information the PSNI provided to the Social Worker even though it later proved to be inaccurate.

Despite the complainant's verbal offer to undertake a full criminal record check the Trust did not process this until ten months later. This inevitably delayed any consideration of the complainant's suitability as a kinship carer. This was primarily

because the Social Work Team failed to obtain the complainant's written consent. I found this to be maladministration.

Although the complainant did not raise the issue of the Trust's record keeping, this investigation found maladministration in the Trust's poor recording keeping and its failure to retain records of its own investigation into this complaint. As a result of this poor record keeping, I could not determine what evidence the Trust relied on to complete its internal investigation into the complaint.

I was very concerned about the Trust's lack of records of the telephone call on 24 February 2021, a telephone call which had very significant consequences for both the complainant and his grandchildren. I consider this caused the complainant to sustain the injustice of uncertainty in the Trust's ability to carry out an accurate kinship assessment. I also consider the Trust's failure to act proactively in the complainant's kinship assessment caused the complainant to sustain the injustice of a loss of opportunity to complete the kinship assessment at an earlier stage.

I recommended the Trust apologises to the complainant for the failings identified in record keeping and the delay in progressing a full criminal record check. I also recommended action for the Trust to take to prevent the failures recurring.

THE COMPLAINT

1. This complaint concerns the actions of the Belfast Health and Social Care Trust (the Trust). The complainant believed the Social Workers did not appropriately assess his suitability for the kinship role[1] of his grandchildren following their removal from the family home in February 2021.

Background

2. On 24 February 2021, following a welfare concern, the Police Service of Northern Ireland (PSNI) visited the family home about which concerns had been raised and immediately contacted the Social Work Team. On the same day Social Worker C (SW C) and Senior Social Worker B attended the family home and the children were removed. SW B contacted the PSNI by telephone to check if the complainant and his wife were suitable to fulfil the kinship role for their grandchildren. SW B decided, based on the information the PSNI provided, the complainant was unsuitable to take up the immediate role of kinship.

3. On the same day (24 February 2021), the complainant provided his verbal consent to the Trust to allow it to carry out a full criminal record check. The Trust did not request this from the PSNI until November 2021.

4. The complainant lodged a complaint with the Trust on 3 March 2021. The Trust initiated an independent internal investigation into issues the complainant raised during the Trust's complaints process. The investigator wrote to the complainant on 17 August 2021 outlining the parameters of the investigation. The investigator provided the complainant with their findings on 28 January 2022. The investigation highlighted several errors on the part of Social Work Team, which included record keeping and a failure to issue forms in a timely manner. The Trust informed this Office the complainant disengaged with the Trust prior to the conclusion of the kinship assessment.

[1] Providing a stable home life where children can grow and develop in a safe positive environment.

Issues of complaint

5. I accepted the following issue of complaint for investigation:

   Issue 1: Whether the Trust acted in accordance with social work standards and procedures when assessing the suitability of the complainant to take up kinship of his grandchildren.

INVESTIGATION METHODOLOGY

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

Independent Professional Advice Sought

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

   - A Social Worker with 34 years' experience across children's and adult services with particular expertise in child safeguarding (ISWA).

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

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

The general standards are the Ombudsman's Principles[2]:

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

- The Principles of Good Administration
- The Principles of Good Complaints Handling

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

    The specific standards and guidance relevant to this complaint are:

    - The Foster Placement (Children) Regulations (Northern Ireland) 1996 (the Foster Placement Regulations);
    - The Children (Northern Ireland) Order 1995 (the Children Order);
    - Standards of Conduct and Practice for Social Workers Northern Ireland Social Care Council November 2015 (Social Work Standards);
    - Health and Social Care Information Sharing Agreement between the Health and Social Care Board and Protective Disclosure Unit (PDU) and Central Referral Unit (CRU) of the Police Service of Northern Ireland 4 November 2019 (Information Sharing Agreement);
    - Urgent Welfare Checks/Sharing of Information Police Service of Northern Ireland 24 January 2019 (PSNI Guidance);
    - Department of Health Guidance in relation to the Health and Social Care Complaints Procedure (Revised April 2019) (DoH Complaints Guidance);
    - Belfast Health and Social Care Trust Policy and Procedure for the Management of Comments, Concerns, Complaints and Compliments March 2017 – March 2022 (Trust Complaints Guidance);
    - Belfast Health and Social Care Trust Records Retention and Disposal Schedule August 2021 (Retention and Disposal Guidance); and
    - Department of Health Good Management Good Records 18 February 2020 (GMGR Guidance).

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

12. I shared a draft copy of this report with the complainant and the Trust for comment on its factual accuracy and the reasonableness of my proposed findings and recommendations. The complainant and the Trust submitted comments in response. I considered all the comments I received before finalising this report.

THE INVESTIGATION

Issue 1: Whether the Trust acted in accordance with Social Work Standards and procedures when assessing the suitability of the complainant to take up kinship of his grandchildren.

In particular this will consider:

- The assessment of kinship; and
- Record keeping[3].

Assessment of Kinship

Detail of Complaint

13. The complainant said he was a *'victim of serious inaccurate allegations'* which the Trust used to prevent him and his wife providing a kinship role to his grandchildren. The complainant said he contacted the PSNI who informed him it had no record of any check made on the day of the children's removal. The complainant said he verbally consented to a full criminal record check on 24 February 2021, however there was a significant delay in the Trust obtaining this information. This meant he was unable to progress to the next stage of the kinship assessment at an earlier point.

Evidence Considered

Legislation/Policies/Guidance

14. I considered the following legislation/policies/guidance:
    - Foster Placement Regulations;
    - Children Order;
    - Social Work Standards;
    - Information Sharing Agreement; and
    - PSNI Guidance.

Trust's response to investigation enquiries

15. In response to the draft Investigation Report the Trust clarified the role of the individual Social Workers involved in the complaint.

[3] The complainant did not specifically raise this issue of complaint, but I identified issues with record keeping during my investigation.

16. In relation to the initial checks the Trust stated the following: it accepted it acted on information received from the PSNI on 24 February 2021 when carrying out immediate safeguarding checks. *'The information received at the time was inaccurate and the Trust has apologised to [the complainant] for the distress this has caused him'*. The Social Work Team based its response on 24 February 2021 to the information it had at that time.

17. The Trust stated, '*No evidence could be found on social work records of the communication between [the complainant] and social workers or between PSNI and social workers with regard to the information shared on the day that the children were removed from parental care'*. Its internal investigation identified the lack of records was due *'to significant staffing shortages within the social work team at the time, resulting in social workers not having the capacity or time to complete their case recordings to the required standard'*.

18. SW B acknowledged she had *'received information from PSNI during initial checks which precluded [the complainant] at that time from being considered as a potential kinship carer'*. In response to the draft Investigation Report the Trust stated SW C, who was with SW B in the family home, telephoned SW A and relayed the information the PSNI provided. SW A contacted the complainant to inform him of the details of the police check as relayed to her and on this basis the children could not be immediately placed with them. SW A recalled the information shocked the complainant and he verbally agreed for the Trust to obtain a formal criminal record check from the PSNI.

19. In relation to the criminal record check the Trust stated the following: it *'apologised for the significant delay in obtaining [the complainant's] written consent for full criminal records check which occurred in the context of staff shortages and the absence of a Senior Social Worker to provide direction to the team with regard to the matter'*. It raised this issue with the management team within the office to prevent the issues arising again.

Relevant Trust records

20. The Trust provided this Office with the relevant Social Work records along with material relating to the complaint investigation. This Office also obtained records from the PSNI in relation to the checks conducted on 24 February 2021.

Relevant Independent Professional Advice

21. In relation to the initial checks the ISWA advised the following: from the Trust's response, neither SW A nor the SW B recorded on the Trust's system the discussion with the PSNI [on 24 February] nor the information the PSNI provided. *'Broadly contemporaneous recording of any significant discussion with other professionals is indicated as a matter of good practice'*. *'The fact this was not done has muddied the waters over what was said by whom in PSNI and whether that was heard or interpreted correctly by the social worker'*. This missing record meant the complainant believed the telephone conversation did not take place.

22. The information from PSNI was either inaccurate or misinterpreted by SW B. The ISWA advised *'even if the information had been heard, understood and recorded correctly at the time, this would still in my view have indicated that there ought to be further exploration before a kinship placement could commence…It is not appropriate or safe for social workers to place children into situations where there is any indication of a history of violence, without a full understanding of that history and the potential risks'*. The initial information the PSNI provided in relation to the criminal record check *'would only have heightened concerns still further'*.

23. In relation to the criminal record check the ISWA advised the Trust did not follow up on the information received from the PSNI in writing. However *'even if the process had been followed, I do not think that this would have changed matters in the immediate future'*. The Trust could have clarified the information received from the PSNI by following its procedure about kinship.

24. The Trust acknowledged the unacceptable delay in obtaining the complainant's written consent for a full criminal record check, and the ISWA advised *'I would agree with this'*.

25. Overall the ISWA highlighted the following failures: failure by the social work staff involved to record initial PSNI checks, failure to follow up procedure in terms of submitting an ISF[4] form and ongoing failure to follow up on ISF submission. The ISWA concluded *'had the Trust acted sooner to gain confirmation of the nature of the incident, this could have been achieved far sooner and the complainant and his wife would have been recommended for approval as kinship foster carers at an earlier point'*.

Analysis and Findings

26. The complainant said the Social Work Team used false accusations to prevent his kinship application. The complainant said SW A informed him the PSNI said he had a previous criminal record. The complainant said he also contacted the PSNI following the Trust's initial checks (24 February 2021). The complainant said the PSNI advised him *'they had no record of any check being made on the day of the children's removal'*.

27. The Children Order states the Trust has a statutory duty *'to safeguard and promote the welfare of children within its area who are in need'*.

28. Following the children's removal from the family home on 24 February 2021, the Social Work records document the Social Work Team considered the complainant and his wife for the role of kinship. The Social Work records document SW B conducted initial enquiries over the telephone with the PSNI. The ISWA advised verbal checks with PSNI *'are a standard means of checking out whether there is any information within their domain that would indicate concern as to the suitability of a placement'.*

29. I reviewed the Social Work records and the contemporaneous records made on 24 February 2021. I note the records do not contain a record of SW B's telephone call with the PSNI on 24 February 2021. I note the Trust

[4] Information Sharing Form used to request information from the PSNI on an individual.

acknowledged to my Office that SW B did not make a record on the Trust's system of the discussion with the PSNI and the information received. However the Trust's records contain an internal email chain (dated 2 December 2021) between SW B and Social Worker D[5] (SW D). In this email SW B advised SW D her notes (presumably handwritten) contain the information the PSNI provided her on 24 February 2021. The Trust has not provided this Office with a copy of this note and we cannot therefore verify their existence.

30. I acknowledge the Social Work records do not contain documented evidence of a telephone call between the PSNI and SW B that took place on 24 February 2021. However I accept SW B did receive information from the PSNI in relation to the complainant's criminal record. This is because SW B knew the PSNI held information about the complainant, and I do not consider she would have known this had she not telephoned the PSNI. I also consider the email referred to information the SW B received information from the PSNI during a telephone call on 24 February 2021. Therefore I am, on the balance of probabilities, satisfied a telephone call took place between SW B and the PSNI on 24 February 2021.

31. I would have expected documentary evidence of the telephone call, and I accept the ISWA's advice *'broadly contemporaneous recording of any significant discussion with other professionals is indicated as a matter of good practice'*. I refer to the Social Works Standards which require Social Workers to maintain *'accurate, complete, retrievable and up to date records'*. The ISWA advised *'the fact this was not done has muddied the waters over what was said by whom in the PSNI and whether that was heard or interpreted correctly by the social worker'*. I also refer to the Third Principle of Good Administration which requires public bodies to keep *'proper and appropriate records'*. I consider the lack of documentary evidence of a record of the telephone call on 24 February 2021 is maladministration. I will refer to the injustice below.

32. I note the Trust acknowledged to the complainant during local resolution *'the information received at the time [24 February 2021] was inaccurate'*.

[5] Social Worker D assumed responsibility for the family in March 2021.

Nevertheless the ISWA advised *'even if the information had been heard, understood and recorded correctly at the time, this would still in my view have indicated that there ought to be further exploration before a kinship placement could commence'*. The ISWA advised this is because if the complainant had come to the attention of the PSNI previously *'this would have been an immediate area of concern'*. I accept this advice and I am satisfied it was appropriate for SW B to take this information into account. However, due to lack of records, I cannot attribute the miscommunication totally to SW B as it is unclear if the PSNI provided SW B with incorrect information or if SW B heard and interpreted the information inaccurately.

33. I note the complainant was 'shocked' at the information shared with him following SW B's conversation with the PSNI. The complainant said he therefore verbally consented to a criminal record check. However I note there was a significant delay in the Trust obtaining this information.

34. The Information Sharing Agreement states when children require placement outside office hours, the Social Worker is to submit an ISF Form to the PSNI's Central Referral Unit (CRU) within 24 hours of the children's removal. The purpose of the ISF Form is to obtain the criminal record of an individual or family member who agreed to take up the role of kinship of the children. This Information Sharing Agreement requires the ISF Form to be accompanied with the *'written consent from the individual'*. The PSNI guidance also outlines the Social Worker is to complete and submit an ISF Form to the CRU within 24 hours of the children's removal from the family home.

35. The Trust's records document on 24 February 2021 the complainant provided his verbal consent to the Trust to carry out a full criminal record check. The records also contain internal email correspondence dated 25 February 2021 between SW A and SW B discussing whether the criminal record check could proceed without the complainant's written consent due to Covid 19. The Trust stated it did not complete the formal process of obtaining a full criminal record check for the complainant in February 2021 *'as the Senior Social Worker [SW*

B] considered that written consent from [the complainant] was necessary and best practice to make the application and that was not obtained'.

36. The records document SW B asked SW A on 25 February 2021 to telephone the complainant and to obtain his details in order to submit the ISF form. I note the records provided do not document a record of SW A contacting the complainant for these details. The records document following receipt of his written consent which was not sought until some 10 months later, SW D submitted a request to the PSNI for a full criminal record check for the complainant in November 2021. The PSNI provided the Trust with a response to this check on 8 December 2021.

37. I note the complainant told the Trust on 24 February 2021 that the information it received from the PSNI was inaccurate. The Social Work records also document the complainant's shock at the information received from the PSNI. The ISWA advised had the Trust followed the Information Sharing Agreement procedure it *'would no doubt have clarified the exact wording of the incident'*. The Social Work Standards require Social Workers to maintain *'clear and accurate records'*. I would have expected the Social Work Team to have urgently taken steps to clarify this information with the PSNI in order to ensure their records were accurate. I am surprised that it did not do so, given the circumstances.

38. I note the ISWA advised *'there was a subsequent failure to follow procedure in terms of submitting an IFS form within 24 hours to gain written confirmation of the information held by PSNI'*. I accept the ISWA's advice *'it is acknowledged by the Trust that this was an unacceptable delay and I would agree with this'*. I accept the ISWA's advice and I refer to the Social Work Standards which require Social Workers to meet *'relevant standards of practice and working in a lawful, safe and effective way'*. These Standards also require Social Workers to be *'personally accountable for [their] actions and able to explain and account for your actions and decisions'*.

39. I find this 10 month delay in obtaining the complainant's criminal record particularly concerning. The complaint file documents the complainant

contacted the Trust on numerous occasions between February 2021 and November 2021 to follow up on his criminal record check, and to request an update on its progress. I also note there is no documented rationale within the Social Work records explaining why the Social Workers did not obtain this written consent at an earlier point. It is clear that Social Workers were not proactive in progressing the complainant's kinship assessment.

40. As part of local resolution the Trust acknowledged and apologised to the complainant for the significant delay in obtaining his written consent for a full criminal record check. The Trust attributed this delay to *'staff shortages and the absence of a Senior Social Worker to provide direction to the team with regard to the matter'*. However I find the Trust's actions in this regard unacceptable. I do not consider SW A or B or D followed the Information Sharing Agreement Guidance, and failed to meet the above standards contained within the Social Work Standards. I also refer to the First Principle of Good Administration which requires public bodies to act in accordance with their own policy and guidance. I consider the failure to clarify the information received from the PSNI and to obtain the complainant's full criminal record check in a timely manner to constitute maladministration.

41. I note the ISWA advised, had the Social Work Team followed the procedure and request the complainant's criminal record within 24 hours, she did not consider *'this would have changed matters in the immediate future'*. The ISWA advised this was because the Trust *'needed to explore further with the complainant and this wife'*. However, it is clear that this further exploration was unnecessarily delayed by 10 months without explanation or rationale.

42. I am satisfied SW B reacted appropriately on 24 February 2021 to the information she received from the PSNI, even if this information was incorrect. However I am very concerned that neither SW A, SW B nor SW D were proactive in progressing the complainant's kinship assessment. SW A, SW B and SW D did not follow the Trust's own internal guidance and the Social Work Standards to ensure its records were accurate and to obtain a full criminal record check on behalf of the complainant to clarify the PSNI's information in a

timely manner and to progress his kinship assessment. I consider this maladministration. I partially uphold this element of the complaint.

43. I consider the identified maladministration caused the complainant to sustain an injustice of a loss of opportunity to engage further in the kinship process and to have his application for kinship progressed and considered in a timely manner. I accept the ISWA's advice *'had the Trust acted sooner to gain confirmation of the nature of the incident, this could have been achieved far sooner and the complainant and his wife would have been recommended for approval as kinship foster carers at an earlier point'*. Although I cannot conclude whether the complainant and his wife would have been granted kinship of their grandchildren at the end of the assessment process, as the complainant and his wife disengaged with the Trust prior to the conclusion of the assessment, it is clear their experience was not a positive one.

Record Keeping

44. During the investigation it became apparent there was a significant issue of a lack of records pertaining to the internal investigation conducted within the Trust. I reviewed the guidance and addressed the Trust's lack of records below.

Evidence Considered

Legislation/Policies/Guidance

45. I considered the following policies/guidance:
    - Trust Complaint Guidance;
    - DOH Complaints Guidance;
    - Retention and Disposal Guidance; and
    - GMGR Guidance.

Trust's response to investigation enquiries

46. The Trust stated *'information obtained during interviews with staff is contained within the response to [the complainant] dated 17 January 2022'*. The investigator did not retain any written copies of minutes/interviews with staff in relation to the complainant's concerns about his kinship assessment when they issued the investigation report. The investigator disposed of their handwritten

notes upon the investigation's conclusion and did not make electronic copies of these notes.

47. The Trust informed this Office *'Staff undertaking complaints investigations are expected to submit all records to the complaints department at the end of the investigation and this did not happen'*. It addressed this with the investigator and issued a reminder to all managers who investigate complaints to keep their records.

Relevant Trust records

48. The Trust provided this Office with the complaints file which contained internal email correspondence. The Trust also provided this Office with its investigation report into the incident.

Analysis and Findings

49. I reviewed the complaint records and the findings of the investigation report into the complainant's concerns about his kinship assessment. I note the Trust did not provide this Office with records of any minutes or interviews the investigator held with Trust staff during its investigation. The Trust stated the investigator disposed of their handwritten notes upon conclusion the investigation. The Trust also stated the investigator did not make electronic copies of these notes.

50. Based on this evidence, I understand why the complainant lacked faith in the Trust's approach to the kinship assessment and is suspicious of the level of investigation conducted into his complaint. I am critical the Trust did not retain records of their investigation. The absence of proper records not only hampers transparency and accountability, but also undermines the integrity of the Trust's investigation.

51. I refer to the DoH Guidance which requires *'all correspondence and evidence relating to the investigation will be retained in line with relevant information and governance requirements'*. I also refer to the GMGR which requires the Trust to review complaint investigation records ten years *'from the completion of the*

action'. I consider by disposing of these records upon the investigation's conclusion, the investigator did not act in accordance with these guidelines.

52. I refer to the First Principle of Good Complaint Handling which requires the Trust to act in accordance with relevant guidance. I also refer to the Third Principle of Good Complaint Handling which requires the Trust to keep *'full and accurate records'*. These are key Principles to Good Complaint Handling. Without such records it is impossible for public bodies to defend its actions and the decisions it makes when challenged. It can also have the effect of diminishing the public's confidence that decisions made are not arbitrary and outside of due process. Further, when any public body in my jurisdiction fails to retain its investigation records, it makes it very difficult for my Office to appropriately investigate that complainant's concerns when they avail of their right to bring their complaint to my office.

53. I acknowledge the Trust identified the investigator should have retained these records following the conclusion of its investigation. Following this Office's enquiries about this complaint, the Trust reminded its staff of the importance of record keeping. I welcome this approach. Unfortunately in the absence of the investigator's records I am unable to fully determine what information the Trust relied on to make its findings in the part of the investigation report which related to his concerns about the kinship assessment. I find this concerning and consider this failing constitutes maladministration.

54. I consider the maladministration identified highlights further why the complainant is suspicious of the Trust's actions in relation to the kinship assessment, and why he cannot be satisfied the Trust carried out a full and through investigation of his concerns. This is because there are no records to base their decision making in relation to the findings of the investigation.

CONCLUSION

55. I received a complaint about the Trust assessment of the complainant's suitability to take up the kinship role for his grandchildren.

56. The investigation found SW B telephoned the PSNI on 24 February 2021, and appropriately responded to the PSNI's information on that day. However it found SW B failed to make a contemporaneous record of the conversation held with the PSNI on 24 February 2021.

57. The investigation also found the Social Work Team failed to obtain written consent from the complainant to obtain a full criminal record check within 24 hours or in a timely manner. This information would have clarified what information the PSNI held on the complainant, and it would have allowed the progression of the complainant's kinship assessment to the next stage. The investigation established the Trust's failure to obtain the relevant record for 10 months following the complainant's verbal consent was unacceptable and is maladministration.

58. I was concerned about the absence of records pertaining to the Trust's internal investigation into the complainant's concerns about his kinship assessment. I considered the absence of records maladministration.

59. In response to the draft Investigation Report the Trust stated it acknowledged the findings of this investigation. It stated all personnel involved have reflected on the lessons to be learned and these lessons will continue to be utilised by these staff and the Trust in terms of learning from experience.

60. I understand the issues in the complaint are of great concern for the complainant and I acknowledge the impact the failings identified in this report had on timeliness of his ability to be considered for a kinship role of his grandchildren.

Recommendations

61. I note the Trust provided the complainant with an apology in relation to the failure to maintain records of its initial checks and the delay in requesting a full criminal record check for the complainant. I recommend the Trust provides the complainant with a written apology for lack of records pertaining to the investigation into the Trust's handling of his kinship assessment. This apology

should be in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019) within **one month** of the date of this report.

62. I recommend the Trust discusses the findings of this report with staff involved and reflect on the case and discuss it as part of their next appraisal.

63. I recommend the Trust reminds relevant staff of the importance of keeping proper and appropriate records in accordance with the Standards for Social Workers[6] and Records Matter[7] (January 2020).

64. I further recommend the Trust undertakes an audit using a random sampling of records. The audit should assess:

    - Documented records of conversations between PSNI and Social Workers;
    - Whether written consent is obtained in line with the Information Sharing Agreement in order to obtain a criminal record check; and
    - Records made and obtained during a complaint's investigation are retained in line with relevant guidance.

    I recommend that the Trust implements an action plan to incorporate these recommendations and should provide me with an update within **six months** of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies). The Trust should take action to address any identified trends or shortcomings and provide this Office with an update of findings and corrective actions as appropriate.

Margaret Kelly
Ombudsman **2023**

[6] Standards-for-Social-Workers.pdf (niscc.info)
[7] Records Matter January 2020 is a joint publication by NI Public Service Ombudsman, NI Audit Office, and Information Commissioner's Office.

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:

Getting it right

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

Being customer focused

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

Being open and accountable

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

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

Acting fairly and proportionately

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

Putting things right

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

Seeking continuous improvement

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