Local Government & Social Care OMBUDSMAN

Report by the Local Government and Social Care Ombudsman

Investigation into a complaint against South Tyneside Metropolitan Borough Council (reference number: 16 005 776)

13 February 2018

The Ombudsman's role

For 40 years the Ombudsman has independently and impartially investigated complaints. We effectively resolve disputes about councils and other bodies in our jurisdiction by recommending redress which is proportionate, appropriate and reasonable based on all the facts of the complaint. Our service is free of charge.

Each case which comes to the Ombudsman is different and we take the individual needs and circumstances of the person complaining to us into account when we make recommendations to remedy injustice caused by fault.

We have no legal power to force councils to follow our recommendations, but they almost always do. Some of the things we might ask a council to do are:

- apologise
- pay a financial remedy
- improve its procedures so similar problems don't happen again.

Section 30 of the 1974 Local Government Act says that a report should not normally name or identify any person. The people involved in this complaint are referred to by a letter or job role.

Key to names used

Mr Y	The complainant
Mrs Y	The complainant's wife
Mr B	A vulnerable adult
Mrs B	Mr B's wife
Mr C	A vulnerable adult
Care agency 1	Mr Y's employer
NHS Trust	Mr Y's employer

Report summary

Adult social care

Mr Y complains the Council did not follow safeguarding procedures correctly. The Council failed to tell him about allegations made against him, or provide an opportunity for him to refute the allegations and provide supporting evidence. Mr Y says officers from the Council failed to update him, and a staff member threatened him. Mr Y says there was a data breach by the Council who told his wife, Mrs Y, information about the investigation before it told him. Mr Y says the Council's failures led to his rejection from a university course, and losing hours from a work placement. Mr Y also says it affected his future earning potential. Mr Y feels there was a vendetta against him and his wife.

Finding

Fault found causing injustice and recommendations made.

Recommendations

To remedy the injustice caused we recommend the Council should:

- apologise to Mr Y for its failure to properly record a safeguarding investigation and the uncertainty this causes;
- pay Mr Y £400 to recognise the impact of avoidable delay, distress, uncertainty and time and trouble caused by the faults identified in this report;
- provide us with a copy of its current procedure, and say how it complies with current law and guidance. (The legislative framework on safeguarding investigations has changed since the events of this complaint); and
- remind all relevant staff of the importance of accurately recording safeguarding meetings and decisions. Recording should show how the Council reached a decision. This should be communicated to staff, and evidence provided to us.

The Council must consider the report and confirm within three months the action it has taken or proposes to take. The Council should consider the report at its full Council, Cabinet, or other appropriately delegated committee of elected members and we will require evidence of this. (Local Government Act 1974, section 31(2), as amended)

The complaint

1. Mr Y complains the Council did not follow safeguarding procedures correctly. The Council failed to tell him about allegations made against him, or provide an opportunity for him to refute the allegations and provide supporting evidence. Mr Y says officers from the Council failed to update him, and a staff member threatened him. Mr Y says there was a data breach by the Council who told his wife, Mrs Y, information about the investigation before it told him. Mr Y says the Council's failures led to his rejection from a university course, and losing hours from a work placement. Mr Y also says it affected his future earning potential. Mr Y feels there was a vendetta against he and his wife.

Legal and administrative background

The Ombudsman's role

2. We investigate complaints about 'maladministration' and 'service failure'. In this report, we have used the word 'fault' to refer to these. We must also consider whether any fault has had an adverse impact on the person making the complaint. We refer to this as 'injustice'. If there has been fault which has caused an injustice, we may suggest a remedy. ***(Local Government Act 1974, sections 26(1) and 26A(1), as amended)***

Adult safeguarding

3. The law has changed since the events of this complaint, but at the time the Department of Health had issued guidance to local authorities and other agencies under section seven of the Local Authorities Social Services Act 1970 about the action to be taken to protect vulnerable adults from various forms of abuse or harm, under the title 'No Secrets'. It made the Council responsible for co-ordinating the consideration and investigation by relevant agencies into circumstances involving the risk of or actual harm to vulnerable adults.

4. The 'No Secrets (2000)' guidance said the objective of an adult protection investigation was to:

- establish facts;
- assess the needs of the vulnerable adult for protection, support and redress; and
- decide about any follow-up action with regard to the perpetrator and the service or its management.

The Council's policy

5. The Council acted under the 'South Tyneside's Safeguarding Adults Procedural Framework, February 2009' which was created in accordance with 'No Secrets (2000)' guidance. The Agreement incorporated standards outlined in the Association for the Directors of Social Services document 'Safeguarding Adults: A National Framework of Standards for good practice and outcomes in adult protection work' which was launched in 2005.

6. The overview of the procedure was:

- the alert;
- the referral;

- safeguarding assessment;
- decision to investigate;
- strategy meeting;
- investigation;
- safeguarding plan.

7. After an alert was referred to the responsible person, that person would decide whether to investigate, if so they would develop a safeguarding strategy agreeing how the investigation would be carried out; this would be done by a multi-agency meeting or discussion. The Council should include all relevant professionals and organisations in the strategy meeting.

8. The investigation includes co-ordinating and collecting information about the safeguarding concern and the context in which it happened. This could involve the use of criminal or disciplinary investigations.

9. On involving the alleged perpetrator, the Procedural Framework said:

- opportunities must always be given to allow the views of the perpetrator to be included within the investigation, safeguarding assessments and safeguarding assessment/investigation meeting, unless to do so would threaten the safety of the alleged victim. The reason for such a decision must be recorded;
- where a staff member or volunteer is the alleged perpetrator, their employing organisation must ensure they are given the appropriate support and their views are represented to the safeguarding assessment/investigation meeting;
- where the alleged perpetrator is subject to legal proceedings, then consideration must be given to informing and involving their representative.

10. The procedural framework says the findings of the investigation should be shared with the alleged perpetrator at least five days before the safeguarding assessment/investigation meeting either verbally, or where possible by sharing the investigation report, unless to do so would threaten the safety of the alleged victim. The reason for such a decision must be recorded.

11. The procedure says the investigating professional will decide if the alleged perpetrator should attend the safeguarding assessment/investigation meeting, but in most cases, it will not be appropriate. However, the Chair should hear and consider the alleged perpetrator's views.

How we considered this complaint

12. We have produced this report following the examination of relevant files and documents and interviews with the complainant and relevant employees of the Council.

13. We gave the complainant and the Council a confidential draft of this report and invited to comment. The comments received were taken into account before the report was finalised.

14. All references to the Council in this report are in regard to its role as the safeguarding authority, acting as the responsible person for the multi-agency safeguarding board.

15. We have examined the Council's safeguarding investigation, its complaint handling and its involvement of Mr Y in the process.

16. We did not investigate the actions of care agency 1, the NHS Trust, or the university as they are not within our jurisdiction.

Findings

17. Mr Y was working as a care worker for care agency 1. Mr Y was due to start a nursing course at university in September 2014. Mr Y resigned as a care worker in June 2014 to start a job as an auxiliary nurse at a local hospital. Mr Y started his nursing job on 7 July 2014.

Allegation one (Mr and Mrs B) and allegation two (whistle-blower)

18. In June 2014 care agency 1 suspended Mr Y's contract awaiting an investigation into allegations made about him. Mr Y says he was not told the reason for the suspension.

19. At the start of July 2014 Mr Y had a disciplinary meeting with care agency 1, this is when he found out the detail of the allegation, that a client's wife (Mrs B) said Mr Y swore at them. Care agency 1 issued Mr Y with a final written warning. Following Mr Y's appeal of the disciplinary action, care agency 1 reduced the final written warning to a first written warning.

20. On 17 July 2014, Mrs B made a safeguarding alert to the Council saying Mr Y swore and potentially neglected her husband. These were the same issues care agency 1 had considered internally during the disciplinary proceedings.

21. The Council arranged a strategy meeting on 25 July 2014. The strategy meeting included relevant bodies including care agency 1, and members of the NHS Trust who were currently employing Mr Y.

22. At the first strategy meeting care agency 1 disclosed that another care worker (whistle-blower) had made further allegations about Mr Y. The whistle-blower said Mr Y made inappropriate comments about the mental state of a vulnerable person, and was not properly completing care tasks. The Council produced an investigation plan and arranged the next meeting for 8 September 2014.

23. In compliance with the investigation plan, care agency 1 wrote to Mr Y telling him it had attended a recent meeting with the safeguarding authority and inviting him to a meeting on 31 July 2014 to discuss some matters about care standards. Mr Y attended this meeting. The issues discussed were the concerns raised by the whistle-blower; Mr Y refuted the allegations.

24. The next stage is for the Council to complete its investigation within 28 working days, it must record and justify any delays. The Council met on 8 September 2014 which was just outside the target timescale.

25. Care agency 1 fed back to the safeguarding meeting that Mr Y denied the allegations and said that Mrs B and the member of staff were lying. Because of the disciplinary action, care agency 1 had already met with Mr Y and discussed the allegations by Mrs B, and asked for his views. Therefore, care agency 1 represented Mr Y's views and the Council included them in the investigation as required by the policy.

26. There is no evidence to support the Council shared the investigation findings with Mr Y before the meeting, as required by its policy, this was fault.

27. The Council did not invite Mr Y to attend, but care agency 1 represented his views, as explained in paragraph 25. The Council decided on the balance of probabilities Mr Y did likely swear, but it was inconclusive whether this caused

Mr B psychological abuse. No party was required to take any immediate action. This decision was only on the incident with Mr and Mrs B, and did not include a decision about the reports of the whistle-blower. The records state the Council dealt with the whistle-blower as a separate safeguarding alert; but we have not seen any evidence to support this. More detail is given in paragraph 38.

28. The Council wrote to Mr Y on 15 October 2014 providing the safeguarding investigation decision about Mr and Mrs B, and Mr C (see below). The Council accepts this was avoidable delay; this is fault.

Allegation three (Mr C's family)

29. In August 2014, the Council received a safeguarding alert from a hospital about missed care calls by care agency 1. During an interview with Mr C's family they made allegations about Mr Y dating back to April 2014. This prompted a new safeguarding alert. These allegations were that Mr Y swore at Mr C, and Mr Y wrongly said Mr C's continence pad was clean.

30. At the first strategy meeting in August 2014 the Council recorded that while care agency 1 was still considering concerns, there was no obligation for Mr Y to attend or be part of any investigation as he no longer worked for care agency 1. While there may have been no continuing potential risk to the care agency's clients, the safeguarding policy says the Council should include the views of the alleged perpetrator in the investigation. It was fault by the Council to not ensure Mr Y's views were represented.

31. The Council produced an investigation plan and agreed to meet again within 28 days or when the investigation was complete. The Council met on 19 September 2014. We have seen a safeguarding report, but no evidence the Council shared it with Mr Y five days before the investigation meeting as required by the policy. This was fault. The Council decided it could not decide matters without hearing Mr Y's views. The Council actioned care agency 1 to invite Mr Y to its office to answer questions about swearing at Mr C, failure to change a continence pad without being prompted, missed calls, times written in logs, and his attitude towards clients.

32. Care agency 1 wrote to Mr Y on 22 September 2014 saying following a meeting with the safeguarding authority it would like him to attend a meeting to discuss care standards; Mr Y attended on 24 September 2014. Care agency 1 put the allegations made by Mr C's family to Mr Y; he refuted the allegations. Care agency 1 reported this was an acrimonious meeting and found Mr Y intimidating. Mr Y agrees the meeting was acrimonious, but denies being intimidating. Mr Y says care agency 1 became aggressive and threw him out of the room.

33. The Council held a multi-agency meeting on 30 September 2014. Care agency 1 represented Mr Y's views, that he refuted all allegations and felt the care agency was conducting a witch hunt against him. The Council decided on the balance of probabilities Mr Y probably did swear at Mr C but could not conclude psychological abuse. The Council decided Mr Y's failure to change a continence pad in line with Mr C's care plan, until prompted by Mr C's family, resulted in neglect.

34. The Council wrote to Mr Y on 15 October 2014 providing the result of the safeguarding investigation.

35. Because of concerns raised by Mr Y the Council offered to reconvene and look at the safeguarding investigations again. The Council offered to review the

investigations into allegations by Mr & Mrs B, and Mr C, but Mr Y only asked for a review of the investigation into Mr C's allegations.

36. The Council held a further multi-agency meeting on 12 June 2015, at which Mr Y was present. A solicitor represented Mr Y and he had his wife there for emotional support. The purpose of the meeting was to allow Mr Y to represent his views as he felt he could not do so in the earlier investigation. Before the meeting the Council instructed an independent social worker who met with Mr Y and completed a report on the facts of the case. The Council failed to share the report with Mr Y at least five days before the meeting as required by the safeguarding policy. The independent social worker concluded there was no evidence that abuse occurred and therefore neglect could not be substantiated.

37. Having considered all the evidence, including that of Mr Y and the independent social worker, the Council decided the incidents reported by Mr C's family did occur. The Council decided Mr Y swearing did not cause Mr C psychological harm, but not changing the continence pad until prompted by family constituted abuse. The Council shared the outcome with Mr Y in writing on 19 June 2015; the letter said if Mr Y was unhappy he could pursue it under the Council's complaints procedure.

Outcome of whistle-blower investigation

38. There is no evidence that information from the whistle-blower was subject to a separate investigation, or that the Council reached a conclusion on that. The Council says it considered the accumulation of safeguarding concerns during the 30 September 2014 meeting and at the 19 June 2015 meeting; it accepts this is not obvious from the minutes. This is fault.

39. The Council considered allegations about Mr Y from various sources covering the following:

- Swearing at vulnerable people and their families.
- Using homophobic language to a family member.
- Inappropriately referring to a colleague about the mental state of a vulnerable person.
- Potential missed care calls.
- Potential fraudulent claims.
- Intimidating behaviour towards a manager.
- Upheld abuse causing harm to a vulnerable man.

The Council weighed up the likelihood of events occurring, on the balance of probabilities, based on these allegations and the information gathered in response.

40. The Council did not seek Mr Y's views on these allegations, or fully investigate them and reach conclusions on whether they occurred.

41. The Council can consider an accumulation of information, and reach a balance of probabilities view; but it must properly record this. The Council must be open and honest on how it reaches its decisions; accurate recording is essential to demonstrate this. The Council's failure to properly record how it made its decision is fault.

Threatened by staff member

42. Mr Y says a Council officer was threatening to him on the telephone. There is no record of the conversation; the officer has left the Council's employment and could not be contacted for comment. We cannot uphold this part of the complaint due to a lack of evidence.

Data breach

43. Mr Y says that his wife telephoned the Council in September 2014 and it told her there were two sets of investigations against Mr Y. There is no evidence to support Mr Y's allegation and therefore we cannot uphold this part of the complaint. Mr Y can contact the Information Commissioner's Office about a breach of his data.

Vendetta

44. The Council was responsible to consider and take necessary action on safeguarding alerts it received. The Council did this. There is no evidence the Council had any vendetta against Mr Y or his wife in doing so.

Employment and university course

45. The Council invited the NHS Trust and the university to multi-agency safeguarding meetings as relevant bodies. The NHS Trust and university carried out their own investigations and reached their own decisions about whether to offer Mr Y shifts at the hospital and a place on the university course. While the decisions taken by these bodies are obviously disappointing for Mr Y, we cannot say they are the result of any fault by the Council. It would be right to advise those bodies of safeguarding allegations and invite them to multi-agency meetings, to protect vulnerable adults from potential risk of harm or abuse. This is in line with the 'Safeguarding Adults Board Procedural Framework'.

Council complaint procedure

46. Mr Y complained to the Council about the way in which it investigated the safeguarding concerns. Mr Y said the Council did not properly consider the available evidence during the safeguarding investigations.

47. The Council refused to investigate the complaint on the basis it was a challenge of a decision Mr Y was unhappy with rather than a complaint about process. However, as Mr Y was complaining about the process and not just the decision the Ombudsman takes the view the Council should have accepted the complaint and put it through its complaints process. At the very least, the Council should have directed Mr Y to us as a potential point of recourse.

Conclusions

48. We appreciate safeguarding investigations would be stressful for an alleged perpetrator, regardless of the result. The safeguarding authority's priority must be to protect vulnerable adults. Certain actions may be taken to achieve that which seem unfair, as they may happen before an alleged perpetrator is even aware of the safeguarding or can have their views heard.

49. The Council did seek Mr Y's views via care agency 1, who represented his views at safeguarding meetings before the Council made any decisions. This was all in line with policy and there was no fault. The letters that care agency 1 sent to Mr Y were vague, but it then clarified the allegations at meetings. However, the policy says the Council should send the investigation report to Mr Y before the investigation meeting. This did not happen, so Mr Y did not have the detail of the

investigations at the relevant time. Sending the investigation report would allow the alleged perpetrator to correct any factual errors before the Council makes its decision. The Council denied Mr Y this opportunity on each of the safeguarding investigations against him.

50. The Council rectified this fault regarding the allegations by Mr C's family when it reheard the matter, involving Mr Y at the meeting. But this was nine months later, and after Mr Y employed a solicitor, so Mr Y was living with distress and uncertainty over that period.

51. The Council failed to accurately record how it cumulatively looked at the allegations, rather than reaching a separate conclusion about allegations made by whistle-blowers. This leaves some uncertainty about whether those issues were properly considered.

52. Mr Y says he rang care agency 1 and the Council to try and gain clarity about what was happening. There is no evidence of the telephone calls so we cannot know what was discussed. However, we have seen in one of the safeguarding minutes that the Council told Mr Y it could not discuss the ongoing matters with him and he would receive the outcome. There is no requirement for the Council to give information to Mr Y other than sharing details of the investigation five days before the safeguarding investigation meeting. Given Mr Y was no longer employed by care agency 1 there was no ongoing potential risk to those service users, so the Council could have given more information in this case. It is something for the Council to consider in future, in terms of balancing the needs of an alleged perpetrator against the need to protect vulnerable adults. We can see that given the various allegations, separate meetings, and limited information from care agency 1, it would be confusing for Mr Y to understand what was happening. The Council should have acted to clarify this when contacted by Mr Y.

53. The Council failed to put Mr Y's complaints through its complaints process. The Council says its complaints procedure is utilised only where there is a complaint that can have some reasonable measure of success on its merits. Given our investigation has established some fault in the Council's safeguarding procedures leading up to the decision, evidently had the Council accepted the complaint there was a reasonable measure of success. Mr Y could have avoided some of his time and trouble, and the Council may have established learning points it could have actioned sooner. The Council should not close its mind to complaints and take the view someone is solely unhappy with a decision, where the complainant is complaining about the procedure leading up to that decision.

54. The Council failed to direct Mr Y to us. There is limited injustice given Mr Y had a solicitor who could have told him about our service, and given ultimately Mr Y did have his complaint considered by us. However, it has caused Mr Y some avoidable time and trouble, and has potentially delayed the outcome.

55. Mr Y says the Council's actions mean he did not qualify as a nurse and spent many months without employment. This impact is caused by the allegations against him, and not by the actions of the Council. The Council had a duty to investigate the allegations and to invite relevant parties, such as the NHS Trust and university, to multi-agency safeguarding meetings. The NHS Trust made its own decision to not offer Mr Y shifts, and the university made its own decision to remove Mr Y from the nursing course.

56. Mr Y says the Council's failure to clarify what was happening, and give him information at the appropriate times, has had an impact on his mental health. The

Council's delays and refusal to consider the complaint has compounded that further. Although the Council has upheld an allegation of abuse against Mr Y, he is still entitled to have his complaints about the process considered and responded to properly.

Recommendations

57. To remedy the injustice caused we recommend the Council should:

- apologise to Mr Y, for its failure to properly record a safeguarding investigation and the uncertainty this caused;
- pay Mr Y £400 to recognise the impact of avoidable delay, distress, uncertainty and time and trouble caused by the faults identified in this statement;
- provide us with a copy of its current procedure, and say how it complies with current law and guidance. (The legislative framework on safeguarding investigations has changed since the events of this complaint); and
- remind all relevant staff of the importance of accurately recording safeguarding meetings and decisions. Recording should show how the Council reached a decision. This should be communicated to staff, and evidence provided to us.

The Council must consider the report and confirm within three months the action it has taken or proposes to take. The Council should consider the report at its full Council, Cabinet, or other appropriately delegated committee of elected members and we will require evidence of this. ***(Local Government Act 1974, section 31(2), as amended)***

Decision

58. The Council failed to provide Mr Y with information about safeguarding investigations against him, and failed to deal with his complaint; this caused injustice to Mr Y. We are satisfied the recommended action is sufficient to acknowledge the impact of that fault and to prevent future problems.