STATES OF JERSEY

STATES OF JERSEY COMPLAINTS BOARD: FINDINGS – COMPLAINT BY MR. B. HUDA AGAINST THE MINISTER FOR HEALTH AND SOCIAL SERVICES REGARDING AN UNRESOLVED COMPLAINT AND ALLEGATIONS OF RACISM (R.148/2018) – RESPONSE OF THE MINISTER FOR HEALTH AND SOCIAL SERVICES

Presented to the States on 12th February 2019
by the Minister for Health and Social Services

STATES GREFFE

RESPONSE OF THE MINISTER FOR HEALTH AND SOCIAL SERVICES

States of Jersey Complaints Board

On 26th October 2018, a Complaints Board Hearing constituted under Article 9(9) of the Administrative Decisions (Review) (Jersey) Law 1982 was held to review a complaint by Mr. B. Huda against the Minister for Health and Social Services regarding an unresolved complaint and allegations of racism.

On 5th December 2018, the Privileges and Procedures Committee presented to the States the findings of the Complaints Board Hearing (*see* R.148/2018).

The Minister for Health and Social Services has considered the Board's Report presented on 5th December 2018, and responds (*as requested by paragraph 4.9 of R.148/2018*) as follows.

The Complaint

As set out at paragraph 1.2 of the Report, Mr. Huda's complaint was that the Department failed to inform/engage with him or allow him a right of reply in respect of a decision to refer concerns about his professional conduct to his regulator, the General Osteopathic Council ("**GOC**").

As noted at paragraphs 2.2 to 2.5 of the Report, it was accepted at the Hearing that there were procedural errors in the way that this matter was dealt with, following the initial assessment of the safeguarding alert and the failure to inform Mr. Huda prior to the referral to the GOC; and that this process was not carried out, as it should have been, in compliance with the agreed policy. This had been communicated to Mr. Huda in letters dated 7th February 2017 and 10th October 2018, in which the Department apologised to Mr. Huda.

The references within the Report to "the potentially serious consequences which flowed from the initial referral" (paragraph 2.5), are of concern, as is the "unfortunate series of events" (paragraph 4.3), the stated need for "any referral to the GOC [to] have been accompanied by robust evidence to substantiate the request for a review to be considered" (paragraph 4.5), and the suggestion that Mr. Huda was "condemned unheard" (paragraph 4.7).

These references suggest that the Board is making a finding that referral to the GOC was unwarranted or unjustified in all of the circumstances. The Minister maintains the Department's position that whilst, regrettably, due process was not followed in relation to this aspect of the investigation, the referral to the GOC was appropriate. Furthermore, the references wrongly attribute to the Department the subsequent actions of the GOC as Mr. Huda's regulator, and the consequences of those actions.

Fundamentally, at the heart of this case was a legitimate concern of the Department to assure the safety and well-being of a vulnerable adult that Mr. Huda had been treating in his Clinic. Complaints were raised by that vulnerable adult about Mr. Huda which resulted in a Safeguarding Alert being raised. It is not suggested by the Board that the raising of that Alert was in any way unjustified or inappropriate.

The Minister assures the Board that the purpose of the subsequent safeguarding investigation is for the protection of the person identified as at risk. It is not an investigation against the person alleged to have caused harm. It is not (nor does it purport to be) a disciplinary or regulatory investigation. If a referral to a professional body is made "*[*the professional body*] will follow their own investigation procedures where a concern is received and it is their decision regarding whether any action will be taken in relation to the individual's professional registration*".

There is no "minimum" level of seriousness required to justify a referral to the GOC, or a need to conduct a prior investigation into the complaint in order to produce evidence (robust or otherwise) in support of the referral. To do so would be to usurp and/or duplicate the role of the GOC itself, and is not the intended function of the Adult Safeguarding Team.

At paragraph 4.6, the Board states that it "offers no comment as to whether the outcome of the investigation by the GOC would have been different if the correct processes had been followed". This suggests that there is confusion regarding the separate roles of the safeguarding team and the GOC. The process followed by the safeguarding team can have had no impact on the GOC investigation, and the scope and content of that investigation was entirely a matter for the GOC.

For assistance to the Board, referrals made to the GOC go through a screening process in which the GOC itself investigates and ascertains whether or not the complaint is sufficiently serious, and/or if there is likely to be sufficient evidence to support it. The GOC (after contacting the osteopath in question) decides whether or not the complaint should proceed further. The osteopath has a right of reply at that stage. Similarly, if the GOC considers that sufficient concerns exist, it is a matter for that body whether or not to hold a hearing before its Professional Conduct Committee. This process (as it should be) is entirely outwith the responsibility and control of the safeguarding team.

Although the GOC hearing ultimately concluded that there was no case to answer, this cannot be understood to imply that the initial referral was not merited. This is not the case, as is illustrated by the fact that the GOC, after conducting an investigation, chose to take this matter to a full hearing of the Professional Conduct Committee. There is no criticism of the decision to make a referral within the GOC's own judgment.

The referral was made as a result of the significant concerns of 2 medical practitioners concerning the treatment that Mr. Huda was providing to a vulnerable adult. As such, it is suggested that the fact of a referral was inevitable, notwithstanding the failure to follow policy. As Mr. Dunne responded to Mr. Huda on 10th October 2018: "*it was right and appropriate that a referral was sent to the appropriate registration body in regard to the activity and treatment provided by you [Mr. Huda] to the individual concerned*".

In relation to paragraph 4.5 of the Report, the safeguarding policy provides for the Adult Safeguarding Team to determine whether a referral should be made to a regulator. Whilst we note the Board's criticism that those undertaking the investigation should not have the final determination, the referral in this regard was made in accordance with the safeguarding policy in place at the time.

Mr. Huda's complaints of financial losses and other consequences are the result of the decisions of the GOC, and not the consequences of the referral.

The Board's Findings

The Minister's response in relation to the Board's findings is as follows:

4.2 The Minister is disappointed that the Board has partially upheld Mr. Huda's complaint on the grounds of Article 9 of the Administrative Decisions (Review) (Jersey) Law 1982 and sets out the reasoning on the body of his response above.

4.3 The Minister does not agree that the Department failed to deal effectively with the complaint made against Mr. Huda.

The Department took entirely the correct procedure to effectively assure the safety and well-being of a vulnerable adult that Mr. Huda had been treating with colonic irrigation in his clinic. As is set out in the main body of this response, complaints were raised by that vulnerable adult about Mr. Huda which resulted in a Safeguarding Alert being raised. The purpose of the subsequent safeguarding investigation is for the protection of the person identified as at risk. It is not an investigation against the person alleged to have caused harm. It is not (nor does it purport to be) a disciplinary or regulatory investigation. If a referral to a professional body is made "*[*the professional body*] will follow their own investigation procedures where a concern is received and it is their decision regarding whether any action will be taken in relation to the individual's professional registration*".

In response to the Board's comment that "*the Department is unable to provide the contemporaneous notes taken at the Safeguarding Strategy meeting at which this unfortunate series of events was initiated*", the Minister notes that Mr. Dunne advised the Board at the Hearing that there were contemporaneous handwritten records following the safeguarding strategy meeting. However, by e-mail dated 19th November 2018, the Department explained that following enquiries with the Safeguarding Manager, it was established that in fact no handwritten notes had been retained from this meeting, and there is no safeguarding policy obligation to retain handwritten notes once they had been typed up. A copy of the e-mail dated 8th July 2015 following the strategy meeting was provided to the Board. It is not possible to clarify with Mr. Dunne which notes he was referring to, as he has left the Department.

4.4 The Minister is pleased that the Board does not accept that there was any malicious or racist intent towards Mr. Huda by the Department.

The Minister notes that the Board refers to the Defamation Proceedings at paragraph 2.8. Those proceedings were dismissed on 16th October 2017 by Mr. Justice Nicklin (the "**Defamation Judgment**"). A copy of the Defamation Judgment was made available in the Hearing bundles. Paragraph 86 of the Defamation Judgment states that –

> *"The Claimant [Mr. Huda] should not have been granted permission to serve the Claim Form on the Defendants in Jersey. The Order granting that permission will be set aside. There being no remaining Defendants against whom the Claim Form has been (or could be) served, the Claim will be dismissed.*

Given its almost inevitable fate, I consider that it was very unwise for this claim to have been brought".

4.5 In relation to the Department departing from policy, the Minister accepts that there were procedural errors in the way that this matter was dealt with, following the initial assessment of the safeguarding alert and the failure to inform Mr. Huda prior to the referral to the GOC; and that this process was not carried out, as it should have been, in compliance with the agreed policy. This was confirmed at the Hearing, and it was confirmed to the Board that this had been communicated to Mr. Huda in letters dated 7th February 2017 and 10th October 2018, in which the Department apologised to Mr. Huda. However, the safeguarding policy provides for the Adult Safeguarding Team to determine whether a referral should be made to a regulator, and whilst we note the Board's criticism that those undertaking the investigation should not have the final determination, the referral in this regard was made in accordance with the safeguarding policy in place at the time, and was appropriate.

In paragraph 4.5, the Board is also critical that the Safeguarding Team "abrogated" responsibility to the patient's G.P. to contact Mr. Huda and advise him to cease treating the patient. It is wholly appropriate that the G.P., who was present at the Adult Safeguarding Strategy meeting and was the patient's own G.P., was the most appropriate professional to act in the best interests of his patient and intervene on that patient's behalf to contact Mr. Huda to ask him to cease treatment in accordance with the agreed plan.

4.6 The Minister notes the Board's comment that it "*offers no comment as to whether the outcome of the investigation by the GOC would have been different if the correct processes had been followed*", and this suggests that there may be confusion regarding the separate roles of the safeguarding team and the GOC. The process followed by the safeguarding team can have had no impact on the GOC investigation, and the scope and content of that investigation was entirely a matter for the GOC.

Referrals made to the GOC go through a screening process in which the GOC itself investigates and ascertains whether or not the complaint is sufficiently serious, and/or if there is likely to be sufficient evidence to support it. The GOC (after contacting the osteopath in question) decides whether or not the complaint should proceed further, and they will seek additional information as part of that investigation.

Although the GOC hearing ultimately concluded that there was no case to answer, this cannot be understood to imply that the initial referral was not merited. This is not the case, as is illustrated by the fact that the GOC, after conducting an investigation, chose to take this matter to a full hearing of the Professional Conduct Committee. There is no criticism of the decision to make a referral within the GOC's own judgment.

4.7 The Minister does not agree that Mr. Huda was '*condemned unheard*'. The safeguarding policy provides for the Adult Safeguarding Team to determine whether a referral should be made to a regulator. The referral to the GOC was appropriate, as stated by Mr. Dunne in his letter to Mr. Huda dated

10th October 2018: "*it was right and appropriate that a referral was sent to the appropriate registration body in regard to the activity and treatment provided by you [Mr. Huda] to the individual concerned*". It is not (nor does it purport to be) a disciplinary or regulatory investigation. If a referral to a professional body is made "*[*the professional body*] will follow their own investigation procedures where a concern is received and it is their decision regarding whether any action will be taken in relation to the individual's professional registration*". The GOC (after contacting the osteopath in question) decides whether or not the complaint should proceed further. The osteopath has a right of reply at that stage. If the GOC considers that sufficient concerns exist, as it is did in this case, it is a matter for that body whether or not to hold a hearing before its Professional Conduct Committee. This process (as it should be) is entirely outwith the responsibility and control of the safeguarding team.

4.8 The Minister thanks the Board for their recommendations and comments as follows –

- The Board advise the existing policies "*should be reviewed to establish a clear differential between the focus on the patient at risk and the disciplinary aspects of any investigation*". The Adult Safeguarding Team have no disciplinary locus in respect of a regulated health care professional. If there are concerns about professional conduct, then it is a matter for the professional regulatory body to consider, and ultimately determine any disciplinary or other sanctions.

- The Minister recognises and appreciates the importance of clear documentation and record-keeping, and thanks the Board for raising the significance of this.

- The Minister advises that the Department has a review of procedures programme following their Annual Report 2017. Consequently, the Policy and Practice Sub-Group will be commissioning an external and independent professional to work in partnership with them to review the safeguarding procedures by the end of 2019. The Department are keen to learn and apply the lessons that can be drawn from the Board's report and, accordingly, following review of the relevant policies, we will be making adjustments where appropriate.

- In relation to each progression of the complaint-handling procedures being signed off by an independent scrutineer, the Minister advises that the Department Complaints Procedure states that the relevant Directorate Manager is responsible for the "first stage – local resolution". They are responsible for ensuring that the investigation of the complaint is carried out appropriately, usually by delegating the investigation to an appropriate manager.

When Mr. Huda made a complaint to the Minister under the Complaints Procedure, it was initially investigated and responded to by Mr. Roberts. As Mr. Huda was not satisfied with the initial response from Mr. Roberts, a further review was undertaken by Mr. Dunne. Neither Mr. Roberts nor Mr. Dunne were involved with the safeguarding referral/original decision-making process. In relation to safeguarding referrals, since early 2018 there has been senior

management oversight of all safeguarding referrals by way of a weekly reporting system. The Department agrees with the Board that clearly-documented records and accurate record-keeping is important, and this is something that the Department strives to achieve.

Concluding remarks

The Minister advises that this is not a case where the decision to refer Mr. Huda to the GOC can be reconsidered. However, the Department has reviewed Mr. Huda's complaint on 2 separate occasions, and on both occasions it was accepted that Mr. Huda had not been notified before the referral to the GOC was made, and the Department has apologised for that step.

Nevertheless, the Minister is satisfied that the Department's decision to refer to the GOC was appropriate in all the circumstances. As presently drafted, the Report could be understood as wrongly conflating the differing duties and purposes of the safeguarding investigation with that of a professional conduct or disciplinary investigation. The safeguarding inspection was not designed or intended to deal with professional conduct or disciplinary investigation, and those were appropriately referred to Mr. Huda's professional regulatory body.

The Minister thanks the Board for the opportunity to respond to the Report and the Board's recommendations and findings.