STATES OF JERSEY

STATES OF JERSEY COMPLAINTS BOARD: FINDINGS – COMPLAINT BY X AGAINST THE HEALTH AND COMMUNITY SERVICES DEPARTMENT IN RESPECT OF A DIVISION OF THAT DEPARTMENT

Presented to the States on 24th May 2019
by the Privileges and Procedures Committee

STATES GREFFE

REPORT

Foreword

In accordance with Article 9(9) of the Administrative Decisions (Review) (Jersey) Law 1982, the Privileges and Procedures Committee presents the findings of the Complaints Board constituted under the above Law to consider a complaint against the Health and Community Services Department in respect of a Division of that Department.

Deputy R. Labey of St. Helier
Chairman, Privileges and Procedures Committee

STATES OF JERSEY COMPLAINTS BOARD

18th October 2018 and 7th December 2018

Complaint by X against the Health and Community Services Department in respect of a Division of that Department

Hearing constituted under the
Administrative Decisions (Review) (Jersey) Law 1982

Present

Board members –

S. Catchpole, Q.C. (Chairman)
J. Eden / G. Marett
D. Greenwood

Complainant –

X

Minister for Health and Social Services –

J. Poynter, Director of Operations, Community Services, Health and Community Services (18th October 2018 only)

S. Devlin, Group Director, Children's Services, Health and Community Services
K. Ogle, Interim Head of Service, Children's Services, Health and Community Service
V. Shearer, Community Psychiatric Nurse, Health and Community Services
Dr. L. Posner, Consultant, Health and Community Services
Dr. C. Power, Director of Specialist Services, Health and Community Services (7th December 2018 only)

States Greffe –

L.M. Hart, Deputy Greffier of the States
K.L. Slack, Clerk

The Hearing was held in private at 10.00 a.m. on 18th October 2018, in the Blampied Room, States Building; and was reconvened in private at 10:00 a.m. on 7th December 2018 in the same location.

Please note that reference within the report to the Health and Community Services Department should be also taken to denote the Health and Social Services Department, as that Department was previously named.

1. Opening

18th October 2018

1.1 The Chairman welcomed the attendees and stated that the meeting would take place in private, due to the highly sensitive nature of some of the evidence which would be heard. He circulated a document, which he had prepared and which summarised what he had identified as the key issues arising from the complaint of X, on which he would have expected to receive a full and detailed response from the Health and Community Services Department ("the Department").

1.2 The Chairman gave an early indication to the representatives of the Department that he was not satisfied with the calibre of the response which they had provided in advance of the hearing. The response did not properly address the issues raised by X in the complaint; did not identify which policies had been applicable at the time of its dealings with X's child ("the child"); did not indicate whether or not those policies had been adhered to; and whether the reorganisation of the Department had resulted in a change of policy.

1.3 Moreover, elements of the Department's submission had been so heavily redacted that they had become meaningless. The Chairman accepted that there was a requirement to protect the confidentiality of the child and the family members. However, he opined, from his experience as a Q.C. in trials relating to terrorism, that it was possible to summarise those sections that had been redacted in such a way that confidentiality was maintained, whilst providing as much information as possible.

1.4 The Chairman stated that he was mindful that X had first made the complaint some time ago, and that there had been a delay in coming to a hearing. To that end, he had wanted to open the hearing, but he felt that in order for there to be a meaningful outcome, it was important for the Department to be given time to address the key issues raised by the Complainant and other issues on which the Board sought a response.

1.5 The Board decided that it required from the Department a chronology of events, to include the actions taken in respect of the child. It also sought responses to the following specific questions –

- Whilst bound to focus on the best interests of the child, what did that actually involve?
- Following the assessment of the child, why had nothing been done to establish a diagnosis?
- Why had no explanation or information been given as to what condition the child had?
- Why had there been a lack of continuity of care?
- Why had decisions been made without all of the relevant factors being taken into account?

- Why had a diagnosis been sought from professionals who had had limited contact with the child, without ascertaining facts from family members, who knew the child best?

- What lessons had been learnt?

- What changes had occurred since this case, and had there been changes in policy which would now address the issues raised in this case?

1.6 The Department was asked to provide responses to both these specific questions and the issues raised by the Complainant in a confidential report, endorsed by the Minister for Health and Social Services, which was to be sent to the Board within 4 weeks of the hearing (Friday 16th November 2018), to enable the Board to reconvene on, or around, 7th December 2018.

1.7 The Chairman adjourned the hearing.

7th December 2018

1.8 The Chairman re-opened the hearing and explained to both parties that Ms. J. Eden, who had been a member of the Board for the initial hearing in October, was unable to attend. Mr. G. Marett had kindly agreed, at short notice, to replace her, subject to both parties not having any objection to this proposal. X and the representatives from the Department indicated that they had no issue with this change.

1.9 In advance of the reconvened hearing, the Board had been provided with a 24-page document, which had been prepared on behalf of the Minister for Health and Social Services, to address the questions raised by the Board in October 2018. The Chairman thanked the representatives from the Department for the time that officers had taken away from other duties in order to compile the paperwork. He indicated that it was the type of response that the Board would hope to receive from a government department in that it was forthright, clear and acknowledged any failings. Whatever the outcome of the hearing, this type of interaction between Complaints Boards and departments of the States should be encouraged.

1.10 The Chairman emphasised that the members of the Board were not qualified to judge the treatment offered to the child, or to question the recommendations made by medical professionals. The Board would consider the processes which the Department had undertaken and the appropriateness of the same.

2. Summary of the Complainant's case

2.1 The key issues raised by X were that a particular Division of the Health and Community Services Department ("the Division") had made no progress with the child over a period exceeding 3 years, until such time as matters had reached crisis point, despite the child having been seen by a number of different people within the Division.

2.2 The Complainant had taken the child to see a G.P. because the child had been displaying certain symptoms and had been experiencing difficulties at school. Following that appointment, the G.P. and X had decided that it would be in the best interest of the child to be referred to the Division. However, over a period of years the child had been dealt with by a variety of different nurse practitioners within the Division, but had had very limited access to qualified professionals, and there had been no consistent record-keeping by employees of the Division. Notes were taken at some meetings, but not at others, which resulted in the same questions being asked, some of which X had described as being of an intrusive nature. The parents felt that the child had been '*moved from pillar to post with different members of staff*' at the Division.

2.3 The Complainant informed the Board that the during the family's dealings with the Division, it had not been provided with any workable strategies, or support, to help the parents deal with the child, despite them having furnished the Division with large quantities of background information and having completed various questionnaires. The child had also become frustrated at having to respond to the same questions time and again.

2.4 The Division had placed the child on medication, which the child had declined to take after a period of time. However, no further medication had then been tried, or suggested, by the Division, and no alternative methods had been offered to deal with the symptoms the child had been experiencing

2.5 After X had raised concerns with the Division over the little progress that appeared to have been made with the child, and the lack of communication with the parents, the child had then been seen and interviewed alone by an independent expert. This expert had written a report on the child, which had subsequently been withheld from the child's parents, despite it containing an allegation made by the child, which the parents had not been given the opportunity to counter. The report had set out what condition it was considered that the child definitely did not have, and had suggested a possible cause of the symptoms on display. The report had been sent to officers within the Division, but the parents of the child had been unaware of the existence of the report until a significant period after it had been prepared (as referenced at paragraph 2.9 below).

2.6 X informed the Board that the Division had not taken any action in relation to the possible cause of the child's symptoms, and had not referred the child for a formal diagnosis. Moreover, the implications of the possible cause of the symptoms had not been explained fully to the parents, nor had any options for treatment been explored with them. As a consequence, the parents felt that they had been prevented '*from getting [the child] the help [the child] needed*'. They were of the view that the Division had '*deliberately not done a diagnosis in order to avoid taking responsibility for any of their key failings*'. The Complainant indicated that he/she would have been willing to take the child to the United Kingdom, or abroad, in order to obtain a formal assessment of the symptoms the child had been displaying.

2.7 Following the meeting with the independent expert, things had '*hit crisis point*', and the ability of the child to cope at school and at home had diminished. At this stage the child had been particularly vulnerable and at risk. The child's relationship with a family member had irretrievably broken down, and this had adversely impacted on the wider family. X indicated that the family suspected that, rather than ask open questions, the expert had made specific suggestions which had contributed to this crisis. X opined that the Division should have involved the parents more fully at this juncture, but instead '*they deliberately shut their eyes to the issues*', had closed the file on the child, which X described as '*incredible*', and had offered no support to the family. X felt that this was a wilful act on the part of the Division and had written, '*It appears to me that it was convenient for the [Division] not to ensure recommendations were followed up so they would not have to make the resources available to help resolve the problem. It is a shame that families have to reach breaking point before anything constructive is done'*.

2.8 At around the same time, the child had notified the Division that he/she did not wish for it to communicate any further with the parents and did not intend to participate in any activity involving them. The Complainant notified the Board that, up until the meeting with the expert, the child had not had an issue with the parents playing a role in the treatments on offer to the child.

2.9 Some months later, the behaviour of the child had caused the family such concern that X had taken the child to see the G.P. It had not been until this time that the Complainant had become aware that a report had been written by the expert who had interviewed the child alone. The Complainant indicated that the family had felt '*shut out*', and that they had been '*denied an opportunity to help [the child]*'. X stated that, as parents, they knew the child better than anyone else and had a valuable contribution to make. Even when they had become aware of the report, the findings contained therein had not been explained to them. They had not received any information on the possible symptoms identified by the expert, and had not been given an apology for not having been provided with a copy of the report

2.10 X had changed jobs, taking a drop in salary in order to be able to provide support to the child and to encourage the child to spend more time in the family home. X informed the Board, '*I was responsible for [the child] and I was willing to do anything to help [the child]'*.

2.11 Throughout the child's involvement with the Division, the parents had felt ostracised, and were of the view that the employees of the Division had failed to appreciate the consequences for the family of the actions that they had taken in respect of the child. They had found the Division to be neither '*helpful*', nor '*proactive*'. '*I know what they have done is not fit for purpose*', X informed the Board.

2.12 X had subsequently complained about the Division to the Department.

2.13 The complaint made by X had also referenced another Service within the Department ("the Service"). That Service had become involved with the family and the child at the time of the crisis highlighted at paragraph 2.7 above, and had been the subject of an earlier complaint made by X.

2.14 Although the parents had initially felt that the Service would be of assistance and had appeared '*genuinely interested in trying to help the situation*', X had subsequently indicated that the employees of the Service had not taken the views of the parents seriously and had not reacted well when challenged. '*We were verbally backed into a corner when we expressed a difference of opinion ... intimidation tactics were being used*'. They had felt '*frozen out*' of the process, and were of the belief that the Service had shown little interest in the child during the most difficult period.

2.15 At one stage, the parents had been invited to attend a meeting with various professionals (Initial Child Protection Conference), following an earlier meeting, to which they had not been invited (Professional Strategy Meeting). They had never been given the rationale for being asked to attend the meeting, and X informed the Board that the officers who had been in attendance had '*painted a black picture*' of the parents and had behaved in a way which was '*bullying*' and '*an abuse of professional powers ... It most certainly did not have any desired outcomes and only proved to put a distance between the family members.*'. It had subsequently emerged that the minutes of the meeting with the parents had been distributed to the other attendees and signed off by the chairman, without the parents being afforded the opportunity to comment on the contents. Most of the people who had been involved with the child had not attended the meeting due to annual leave commitments, and their replacements had known little about the parents.

2.16 X alleged that the reports, which had been prepared about the parents and family members in advance of this meeting, were '*incorrect*', had been written '*with malicious intent*', and had breached data protection legislation. The Complainant contended that the actions of the Service when dealing with the child had caused significant adverse impact on the parents and the wider family, and the Service had failed to act appropriately in its dealings with them and the child.

2.17 Several months after the meeting, an employee of the Service had met with X in the family home in order to discuss future plans for the child. When the Complainant had raised concerns that the child had been denied access to a wide range of professional services, the employee had '*responded by rolling [their] eyes to the ceiling'*, which X had found to be rude, disrespectful and unprofessional, and which did not *'set the tone for a constructive meeting in order to discuss the needs of [the child]*'. When X had challenged views expressed by the employee, the latter had become very angry and '*aggressive*', had opined that X was not '*looking after the best interests*' of the child, and had walked out of the meeting.

2.18 When X had complained about the Service, it had failed to properly acknowledge the complaint, or to deal expeditiously with the same. The Complainant indicated to the Board that basic communication between the parents and the Service had fallen down, and the parents felt that the Service had '*diverted the fault*' onto them and behaved in a '*disgraceful*' way.

3. Summary of the Minister's Case

3.1 A representative from the Department opened by apologising to X for the time it had taken for the Department to respond to X's complaint, which the representative described as '*far too long*', and for the behaviour of one of the employees of the Service, when rolling their eyes (as detailed in paragraph 2.17 above), which the representative accepted was '*not appropriate*'. It was emphasized that throughout the Department's dealings with any child, the Department's aim was to put the child's best interests first, whilst acknowledging that this could be difficult for families, especially parents.

3.2 In response to the assertion that there had been a lack of engagement with the parents, it was noted that the child had been in contact with the Division on several occasions over a number of years. It was contended that during that time, the family had been involved in attending sessions with the child. Moreover, the parents had been sent letters at the end of each period of engagement, detailing the involvement of the Division with the child, and setting out the rationale for 'closing the file' at that juncture. The representative from the Department indicated to the Board that there was significant evidence within the files that communication with the family had been attempted on several occasions, both in person and in writing. In some cases the invitation to the parents to engage with the Division and Service had been taken up, and at other times it had been declined.

3.3 In relation to the report, which had been prepared after the interview with the child, the Department indicated that the individual had, in fact, not been an independent expert, but a qualified professional, working for the Division. The Department acknowledged that it was normal practice for such reports to be shared with relevant parties, to include the parents of a child. Since the complaint by X, the report had been reviewed, and no reason had been identified to demonstrate why it should not have been shared with the parents. A clerical error was believed to have been the reason for this, and it was noted that an apology had been offered to the Complainant in this regard, both in person and in writing.

3.4 It was accepted that the impact on the parents of not seeing this report, or even being aware of its existence until a significant time after it had been drafted, had been to create a sense of frustration and distrust. It was noted that, as a result of this incident, the Division would introduce a random audit of letters to ensure that any similar errors were identified and addressed. '*We need to go away and ensure that any new members of staff are aware of how information is communicated to people involved with the [Division]*', the Board was told.

3.5 The child had been in contact with the Division on a further occasion, and the Board was informed that, at this time, the child had withdrawn consent for details of the care and treatment received from the Division and the Service to be shared with the parents. Thereafter, any dealings with the child had been conducted on a confidential basis. It was explained that parental responsibility for a young person gradually diminished as they grew older, even if they were still legally a minor.

3.6 It was accepted that, in line with the Department's confidentiality policy, the public interest in child protection overrode the public interest in maintaining confidentiality, and that confidential information could be disclosed if it was necessary to safeguard a child. In this case, X had been notified that he/she could contact employees from the Division to express any concerns in relation to the child, but could not receive any information about any work which was being done with the child. It was noted that, despite the age of the child, it had been determined that the child was competent and had the capacity to withdraw consent for the parents to be informed of their dealings with the Department. The child's capacity in this regard had been kept under constant review, and had not been in doubt.

3.7 Another representative from the Department indicated to the Board that as parental responsibility for a child diminished, it could be very challenging for the parents, and it was important for the Department to acknowledge the impact on them, and to be clear with them about what the process would involve, and the legal parameters thereof. In cases where the young person withheld consent for information to be disclosed, the highly skilled employees from the Division would encourage them, at every opportunity, to share. The case of the child was described as '*highly unusual*', because the child had persistently declined permission for their information to be shared. If a young person could not trust the Division, there was the risk that they would not access any support, so the retention of the young person's trust was a priority for the Division.

3.8 The approach taken by the Division when working with young people was 'flexible' and assessed on an individual basis. Sometimes, family members would be involved, but it was not unusual for young people to be seen alone. Moreover, the number of employees of the Division that would have contact with a person would vary. Each person who had contact with the Division would experience it differently, and some found it beneficial to deal with different employees. The period of time for which people would engage with the Division would also vary, but it was not considered good practice for this to happen over a long period of time. It was preferable to close a case, and for it to be re-opened in the future if it was deemed necessary, to prevent dependency.

3.9 In respect of the assertion that the Division had not taken any action in relation to the possible cause of the child's symptoms, and had not referred the child for a formal diagnosis, the Department agreed that the qualified professional had identified what condition it was considered that the child definitely did not have, but indicated that later work with the child had not been able to diagnose the condition that the parents had suspected that the child might have. The child had not given consent for a further assessment, and the child had been of an age where the Division had deemed the child to be capable of making an informed decision, so the assessment had not been undertaken.

3.10 The Board was informed that the Department had reviewed the reports held on file, which the Complainant had described as having been written with 'malicious intent', but had not found any evidence of this. However, reference had been made to an independent review, which had been undertaken by the States of Guernsey into X's complaint to the Department, in which it had been found that, '*The reports do not differentiate between fact (which would require back-up to verify) and what is merely an opinion'*. The representative from the Department informed the Board that there had been no wilful attempt to cause upset to the parents, and the representative queried what the Service would have to gain from so doing.

3.11 With respect to X's claim that the parents had not been sent the draft minutes of the meeting that had been held with the various professionals (referenced at paragraph 2.15 above), the Department's submission was that usual practice would have been for the parents to have received a paper copy of the minutes, which would have been watermarked accordingly. Another copy, with the same contents, but a different watermark, would have been sent to the professionals. Copies of both versions had been retained on file, and the Department indicated that it would have been extremely unusual if they had not been sent out to the parents.

3.12 In relation to the same meeting and the way that the parents had felt when attending, the representative from the Department stated that the purpose of such meetings was to ensure that all the relevant people were in a room together in order to have a discussion about the needs of the child. It was intended to be a constructive, rather than threatening forum, but it was acknowledged that '*they can be difficult for families*'. The Chairman suggested that the parents should have been given advance notification of what would be discussed at such a meeting, and was informed that a representative from the Service had attended the family home some days prior to the meeting to explain the process, but it was accepted that the parents might have a different opinion. The Board was informed that meetings such as that referenced in paragraph 2.15 could make the parents anxious, and officers would attempt to be sensitive, but the representative from the Department conceded that this '*may not always be felt*'.

3.13 The Department accepted that the case in relation to the child was '*complex*' and '*unusual*'. The representative from the Department informed the Board that people sometimes felt that a diagnosis was required in order to enable the correct support and additional services to be accessed. In this case, there had not been a diagnosis, but the Department would not have had a reason for not giving a diagnosis if it had been possible. '*I understand why they feel there is a barrier'*, the representative stated. They argued that the Department had sufficiently communicated to the parents the options that had been considered in relation to the child; the treatment that had been provided, and the opportunities for future treatment. Moreover, it was contended that the type of treatment that had been offered to the child would have been the same, irrespective of whether a diagnosis had been obtained. However, they conceded that it would have been frustrating for the parents, and acknowledged the breakdown in communication between them and the Department.

4. Closing remarks from the Chairman

4.1 The Chairman thanked both parties for their time and contributions. He informed X that it was evident from everything that he/she had said that they cared passionately for the child. He commended them for the remarkable dignity and clarity with which they had expressed themselves, and voiced sympathy for the situation in which they found themselves. He indicated that this was a sensitive case, which had profoundly moved the members of the Board on a personal level, and opined that this was an example of how agencies, in endeavouring to protect the interests of one person, could cause harm to others, albeit not intentionally.

4.2 The Chairman reiterated his appreciation to the representatives from the Department for the work that they had undertaken since the first hearing to respond to the Board's questions, and asked that his thanks be conveyed to all involved in the preparation of the documents.

4.3 The Chairman stated that a report of the hearing would be prepared in due course, which would be circulated to both parties for their input on the factual content. Mindful of the sensitive nature of the evidence, care would be taken to make the report as neutral as possible. Thereafter, the Board's findings would be appended thereto.

5. Findings

5.1 The Board agrees that there were 3 distinct periods for consideration. The first was the period when the child was first referred to the Service. The second was the period following the report by the expert, and thirdly the period following the child's withdrawal of consent.

5.2 The Board is mindful that the complainant considered that there had been a definite lack of communication and continuity of care during the initial period of involvement with the Service. However, the Department had maintained that letters had been sent. It is, therefore, difficult for the Board to reach a conclusion, but the Board is in agreement that parental involvement, explanation of treatment goals and projected outcomes, should form a key part of the dialogue between the Service and parents to ensure there was full engagement on both sides. The sense from the parents was that this had not been the case, and they instead felt disenfranchised from their child's care.

5.3 The meeting with the expert and subsequent reaction to this is of concern to the Board, and they question whether it is common practice for staff to hold interviews alone with vulnerable children. The Report should have been a catalyst for further assessments to be undertaken, in order to reach a definitive diagnosis, upon which the family could act.

5.4 However, the outcome was that the child, having witnessed the parents' reaction to some of the inferences made, and the distress caused to them as a consequence, withdrew consent for the family to be informed of any ongoing care plan, which further exacerbated their sense of dislocation from their child's support. Clearly, the parents, who had instigated the engagement with the Service and had a 3-year history prior to the point where the consent was withdrawn, were seriously invested in finding care and support for their child, and it must have been extremely distressing to have effectively had the tables turned upon them, and faced criticism of their parenting and allegations of negligence from the very Department from whom they had repeatedly sought help.

5.5 The Board acknowledges the difficulties which were inherent in maintaining links with the parents once consent had been withdrawn, but believes it should have been possible to have devised a care plan which allowed parental involvement without betraying the confidence of the child. Ultimately, the people who had the strongest desire to help and support the child, and who knew the child best, were excluded from the process and made to feel part of the problem, rather than the solution. This cannot be right. Any service which cares for children has to also look after the wider family unit. Indeed, the Government of Jersey's Common Strategic Plan includes this as one of its five priorities – *Improve Islanders' wellbeing and mental and physical health – by supporting Islanders to live healthier, active, longer lives, improving the quality of and access to mental health services, and by putting patients, families and carers at the heart of Jersey's health and care system.*

5.6 The focus of care should not be solely on the recipient. There is an obvious impact on those closest to them, and a holistic view has to be taken. In this case, it appears that the child was quite rightly the priority, but the system shut out the very people who had sought help for their child and wished to play an active role in that child's ongoing care.

5.7 A concern throughout the case was the lack of continuity of care. The fact that there was also often poor and inaccurate record-keeping made this a source of frustration to the complainant, and every effort must be made to ensure that accurate and timely notes are taken at every interaction with parents and their child, so that vulnerable people, particularly when imparting highly emotive and difficult information, do not have to repeatedly rehearse their whole back-story each time they meet with a new member of staff. The Board acknowledges that the staff of the Service face enormous stress in their working environment, and that there had been considerable staff movements over the timeframe of this case; however, that made the provision of comprehensive handover notes even more vital.

5.8 The Board recognises that the situation post the withdrawal of consent was exceptionally difficult for the family. Their trust in the Service was fractured, and they remained concerned that their child was not being adequately supported. The Service was placed in a difficult position, because the withdrawal of consent prevented them entering into a meaningful dialogue with the parents to allay their fears. The Board accepts that the withdrawal of consent was very unusual, and acknowledges that the Service encouraged the child to reconsider this decision, to no avail. However, the Board does feel that there

should have been some effort made to identify an appropriate way of relaying some basic information to the parents, simply to advise them that care was continuing, in order to dispel their concerns, rather than completely terminating communications.

5.9 The Board has to consider whether the complaint can be upheld based on the following criteria –

(a) was contrary to law;

Clearly the Service adhered to its policies and procedures when the child withdrew consent. Although it recognises that this was a highly unusual situation, the Board recommends that some consideration is given to identifying a means of providing assurances to a parent that a treatment/care plan remains in place, without betraying the confidence of the child, should this situation arise again in the future.

(b) was unjust, oppressive or improperly discriminatory;

The Board considers that, whilst the Service focused on the rights of the child, it did so at the expense of the parents, who subsequently lost faith and trust in that Service, having been unfairly accused of neglect. The Board recommends that positive engagement with the family unit is given greater emphasis in future service delivery, so that '*patients, families and carers'* are indeed placed *'at the heart of Jersey's health and care system'*, in accordance with the aims of the Common Strategic Plan.

(c) as based wholly or partly on a mistake of law or fact;

There was clear miscommunication between the complainant and the Service, and this fostered a sense of mistrust, which resulted in a complete lack of faith in the Service's ability to provide proper care for the child. That there was a care plan in place could have been communicated to the parents, without divulging details and breaching confidentiality. Instead, the parents were left to glean very limited information from their child where possible, and had experienced years of uncertainty, frustration and worry as a consequence.

(d) could not have been made by a reasonable body of persons after proper consideration of all the facts;

The Complainant had sought a diagnosis for the child, in order to have a greater understanding of how best to deal with the behaviours presented. Without a clear understanding of what the child's difficulties were, the family felt ill-equipped to deal with the behaviours displayed, and were desperate to find coping mechanisms which eased the impact on both the child and the family unit. This had been clearly communicated by X when the first approach had been made to the Service, yet had been discounted over time to the point where X was accused of being negligent and neglectful. It is difficult to see how the Service could disregard such an earnest request for help, and misconstrue the parents' frustration with the Service and its staff, for neglect.

(e) was contrary to the generally accepted principles of natural justice.

Natural justice dictates that everyone should be treated fairly and be heard equally without bias. X felt excluded from the ongoing care process, for a child who was clearly experiencing difficulties. It was not the Service's fault that the child decided to withdraw consent for the family to be advised of the ongoing treatment plan, but that child's decision was made after witnessing the clear impact that direct interactions with the Service had had on the family. It can, therefore, be argued that, had those previous interactions been more empathetic, and less stressful and adversarial, then what was a quite extreme and unusual decision would not have been taken, and the family would have remained a vital and integral part of the ongoing care process, and much of the distress, uncertainty and trauma they had all endured in the intervening period could have been avoided.

5.10 This was a very complex case, and the Board wishes to make it clear that it respects the work which the Service provides in the Island to countless children and families. However, it must be accepted that in this particular case, mistakes were made, communication was poor, and record-keeping was limited and inaccurate. Little effort was made to establish a positive working relationship with the very people who had sought help for their child from the Service in the first place, and whilst the Board was assured that the young person concerned had continued to receive care and support, it cannot be right that the family were excluded from the process in such a stark way, and made to feel that they had been inattentive to their child's needs. In recognising that this was a unique case, the Board reminds the Minister that duty of care extends to '*patients, families and carers*', and that whilst it is laudable for the child to be central to the Service, there is a risk that viewing that child in isolation from its family could foster a culture of parental blame and alienation. Parents must be actively encouraged to play a participatory role – sadly in this case they were actively discouraged by the actions of the Service towards them.

5.11 The Board understands that the Service has already undertaken detailed reviews of its policies, particularly in response to the Independent Jersey Care Inquiry. As the Board is not privy to the outcome of all of those reviews insofar as they may be relevant to the present case, it recommends that a further review is undertaken to assess the extent to which the current policies either adequately address the matters raised in this instance, or could be improved for the future.

5.12 The Board suggests that the findings of such review and the actions taken or proposed to be taken, should be submitted by the Service to the Minister for Health and Social Services, and should provide the basis of the Minister's formal response to the Board's findings within 3 calendar months of the publication of this Report.

Signed and dated by –

S. Catchpole, Chairman .... Dated: ....

G. Marett .... Dated: ....

D. Greenwood .... Dated: ....