AGENDA ITEM NO. 5

STANDARDS COMMITTEE - 21ST JANUARY 2009

SUBJECT: REPORT FROM PUBLIC SERVICES OMBUDSMAN FOR WALES

REPORT BY: MONITORING OFFICER

1. PURPOSE OF REPORT

1.1 To note the report from the Public Services Ombudsman for Wales on a maladministration complaint made against Caerphilly County Borough Council.

2. LINKS TO STRATEGY

2.1 The Authority is under a statutory duty to consider reports from the Ombudsman and to give effect to their recommendations. The duty to oversee this is within the terms of reference of this Committee.

3. THE REPORT

3.1 Since 1st April, 2006 the Public Services Ombudsman for Wales ("the Ombudsman") has had jurisdiction under the Public Services Ombudsman (Wales) Act 2005. This Act has superseded but not completely repealed the previous legislation (Local Government Act 1974) and deals with maladministration complaints made to the Ombudsman.

3.2 There are two forms of report - Under Section 16 which is the form of report which needs to be formally considered by the Authority and Section 21 where the Ombudsman feels that a public report is not required and the matter has been satisfactorily resolved.

3.3 This report before Members is in relation to an Ombudsman report under Section 21 and the report is attached at Appendix 1.

3.4 The maladministration complaint arose from a complaint to the Ombudsman by the person identified in the report, as Mr. & Mrs. H. who complained about the standard of care provided his late step sister-in-law (Mrs. J.) by Gwent Healthcare NHS Trust ("the Trust) and the Council. In particular Mr. H. complained that the Trust and the Council failed to take proper account of his concerns about the risks caused by Mrs. J.'s deteriorating physical and mental state, and that this led to her being inappropriately returned home after a period of respite care. Mr. H. also complained about the standard of communication with him as Mrs. J.'s nearest relative: in particular he was only made aware of a multi-disciplinary team meeting I October 2006, two days before it was held, and consequently unable to attend.

3.5 The Report sets out a detailed chronology of events and details the investigation undertaken by the Ombudsman. The conclusions of the Ombudsman are set out in paragraphs 64-71.

3.6 The recommendations of the Ombudsman are set out at paragraph 72 of the Report.

3.7 Relevant Officers and the Trust have been consulted on the Report and the recommendations of the Ombudsman were accepted.

3.8 Relevant Officers have been consulted on the terms of the Report and the recommendations of the Ombudsman were accepted.

4. FINANCIAL IMPLICATIONS

4.1 None.

5. PERSONAL IMPLICATIONS

5.1 There are no personnel implications arising from the terms of the Report.

6. CONSULTATIONS

6.1 There are no consultation responses which have not been taken into account in the recommendations to this report.

7. RECOMMENDATIONS

7.1 That the Ombudsman's report be noted.

8. REASONS FOR THE RECOMMENDATIONS

8.1 To satisfy the Council's statutory duties under the Public Services Ombudsman (Wales) Act 2005.

9. STATUTORY POWERS

9.1 Public Services Ombudsman (Wales) Act 2005, Local Government Act 1974.

Author: Gail Williams, Principal Solicitor (Corporate/Deputy Monitoring Officer)

Consultees: Chief Executive Officer, Head of Legal Services/Monitoring Officer
Director of Corporate Services, Head of Corporate Finance,
Director of Social Services, Assistant Director for Social Services, Councillor Colin Mann, Chair of the Standards Committee

Background Papers:
None other than published documents

Appendices:
Appendix 1 Report of Public Services Ombudsman for Wales dated 4th September, 2008.

APPENDIX 1

Report under Section 21 of the Public Services Ombudsman (Wales) Act 2005 of an investigation into a complaint made against Gwent Healthcare NHS Trust and Caerphilly County Borough Council

INTRODUCTION

1. This report is issued under Section 21 of the Public Services Ombudsman (Wales) Act 2005. In accordance with the requirements of this Act, details which might identify individuals have been omitted so far as that can be done without impairing the effectiveness of the report. The report accordingly refers to the complainant as "Mr H".

THE COMPLAINT

2. Mr H complained about the standard of care provided to his late step sister-in-law ("Mrs J") by Gwent Healthcare NHS Trust ("the Trust") and the Social Services Department of Caerphilly County Borough Council ("the Council"). In particular, Mr H complained that the Trust and the Council failed to take proper account of his concerns about the risks caused by Mrs J's deteriorating physical and mental state, and that this led to her being inappropriately returned home after a period of respite care. Mr H complained, too, about the standard of communication with him as Mrs J's nearest relative; in particular that he was only made aware of a multidisciplinary team meeting in October 2006 two days before it was held, and was consequently unable to attend.

THE INVESTIGATION

3. I obtained comments and copies of relevant documents from the Trust and the Council, and considered these in conjunction with the evidence provided by Mr H. I also visited Mr H and his wife to discuss their concerns in more detail. I obtained advice from two of the Ombudsman's professional advisers – an

experienced senior nurse and an experienced registered social worker. Their advice is summarised at paragraphs 45 – 63. I have not included every detail of the investigation in this report, but I am satisfied that no matters of significance have been overlooked.

THE RELEVANT LAW, GUIDANCE, POLICY AND PROCEDURE

Mental Capacity

4. The common law requires that a person is deemed to have mental capacity to make decisions unless shown otherwise.[1] The then Lord Chancellor's Department issued guidance to healthcare professionals on helping people who have difficulty making decisions for themselves.[2] This includes:

> "Every adult has the right to make his or her own decisions about health, legal, financial and other matters and is assumed to have capacity to do so unless it is proved otherwise.
>
> "Even with help and support, however, some people do lack capacity to make some decisions and these may need to be taken for them. An assessment must be made in each case.
>
> "Doctors must consider whether the person has the necessary capacity to make each particular decision at the time that it has to be made...
>
> "Before giving an opinion, the healthcare professional should make every effort to help and support the person to maximise their potential to make their own decisions..."

[1] The statutory position has since changed with the coming into force of the Mental Capacity Act 2005 from 1 October 2007.
[2] "Making Decisions: a guide for healthcare professionals", LCD, May 2003

5. Similar guidance was issued at the same time which was aimed at social care professionals.[3] This advises that where a person is deemed to lack capacity, people must act in their "best interests". The guidance states that when determining a person's best interests, their known wishes and interests must be taken into account.

National Guidance

6. The Welsh Assembly Government has published guidance on the assessment and management of care for those using health and social care services.[4] This states that an evaluation of a person's assessed needs should take full account of how their needs and risks might change over time, both over the short and long term. The guidance states that professionals should consider the risks to the person and others, and which risks cause serious concern and which might be acceptable. It advises that "well developed risk assessment is essential to assess the likelihood of changing need and the impact on [the person's] independence."[5]

EVENTS LEADING TO THE COMPLAINT

7. Mrs J lived alone in sheltered accommodation owned by the Council. She had a long term history of depression and was receiving formal support from home carers, together with informal help from Mr H and her neighbours. By June 2006, her condition had deteriorated both physically and mentally; she had lost weight, and was becoming increasingly frail and confused.

8. As a result of Mrs J's increased confusion, a number of incidents occurred. These included: Mrs J attempting to wander outside late at night; her living room carpet being found smouldering due to discarded cigarettes; an explosion caused by Mrs J using unsuitable crockery in the microwave; Mrs J using a watering can

[3] "Making Decisions: a guide for social care professionals", LCD, May 2003
[4] "Health and Social Care for Adults: creating a unified and fair system for assessing and managing care", WAG, 2002
[5] Ibid; paragraphs 2.36 and 2.37

to clean the kitchen floor; and damage caused by Mrs J attempting to clean using stepladders and long handled brooms. A number of measures were put in place to address these risks, such as her cigarettes being removed by Mr H, and appliances being unplugged on the instructions of Mrs J's social worker ("the Social Worker"). On 17 October 2006, Mrs J's mental state was assessed by her consultant psychiatrist ("the Consultant Psychiatrist"). There is no formal entry in the clinical notes about the outcome of this assessment, but a letter sent to Mrs J's GP on 6 November 2006 by the Consultant Psychiatrist states that:

> "[Mrs J] had significant cognitive impairment and lacked capacity. She failed to understand her social environment and was not aware of the risk she presents...
>
> "Therefore we should act in her best interests."

9. Due to her increased physical frailty, Mrs J was assessed as needing a shower to replace her bath, and it was arranged for her to be admitted to a care home ("the Home") on 30 October 2006 while the works were being carried out. Mr H, however, argued that Mrs J should remain at the Home as he felt there would be unacceptable risks to Mrs J and other residents (from, for example, fire), were she to return to her flat. A meeting was held with Mr and Mrs H on 21 November 2006, at which Mr and Mrs H reiterated their concerns. However, the professionals involved argued that Mrs J had expressed a clear preference to go home, and that measures would be put in place to reduce risk. These included the installation of an audible warning message which would ask Mrs J not to go outside should she attempt to wander at night.

10. Mrs J was taken back to her flat on 28 November 2006; however, during the evening of 2 December 2006 she was found wandering in the street in the rain wearing a nightdress. Mrs J was subsequently readmitted permanently to the Home. Sadly she passed away in March 2007.

11. Mr H first raised his concerns formally with the Trust's Chief Executive in a letter dated 15 November 2006. He enclosed an earlier letter (dated 9 November 2006) about the same subject, which he had sent to Caerphilly Local Health Board. In his letters, Mr H stated that due to the incidents that had already occurred, and Mrs J's rapid mental and physical deterioration, she was no longer safe to be left alone in her flat for 15 hours every night after her home carers had left. He was concerned that the Consultant Psychiatrist, Mrs J's community psychiatric nurse ("the CPN"), and the Social Worker, had all decided at a meeting of 20 minutes duration on 17 October 2006 that Mrs J should remain at home. Mr H also raised concerns that the CPN had taken Mrs J to her flat on 14 November 2006 to view the new shower without informing him in advance.

12. On 12 December 2006, Mr H wrote again to the Chief Executive of the Trust. He explained that there had been a multidisciplinary team meeting on 21 November 2006 at which he and his wife had been "outvoted" on the question of whether Mrs J should return to her flat. He said that she was taken home, but found wandering the street in her nightdress five days later. He said he could not understand how Mrs J had been considered able to care for herself in the community when the evidence to the contrary was overwhelming. He questioned, too, how she could have been assessed as able to live on her own, yet five days on was categorised as eligible for admission to an EMI (Elderly Mentally Infirm) residential home.

13. The Trust's Chief Executive wrote to Mr H on 14 December 2006 (this letter appears to have crossed in the post with Mr H's letter of 12 December). He explained that the CPN and the Social Worker had both been aware of the incidents described in Mr H's correspondence, and had taken steps to minimise risks by (for example) unplugging the microwave.

14. The Chief Executive said that it was "regrettable" that Mr H had not been able to attend the assessment on 17 October 2006, and acknowledged that it might have been appropriate for it to have been postponed to allow him to do so.

However, he said this needed to be balanced against the need for the assessment to be done within a reasonable period of time, and the fact staff would have arranged their diaries around the date which had been set.

15. The Chief Executive said it was appropriate for the CPN to have taken Mrs J back to visit her flat to see the new shower, and to maintain the link with her home; however, he apologised for the fact Mr H was not informed of the visit beforehand. He said that although the weather was inclement on the day in question, Mrs J was suitably dressed and the flat would have been warmed by the general temperature of the complex.

16. The Chief Executive said the Consultant Psychiatrist had written a letter (dated 6 November 2006) in which he summarised the outcome of the meeting on 17 October 2006. He explained that this letter identified areas of risk, and included a statement "to the effect that" Mrs J lacked capacity. The Chief Executive said that if a person lacks mental capacity, the team will act in their best interests. He said the team believed they were doing so in this case. He acknowledged that up to that point there was little or no evidence of documented risk assessment on file, albeit a comprehensive written risk assessment had since been done by the Social Worker. He said, too, that before Mrs J returned to her flat an audible alarm and warning notices were installed to reduce the risk of her wandering outside.

17. Finally, the Chief Executive said they would make every effort to ensure that Mr H was involved in future care decisions, and apologised for the CPN not having returned his calls on some occasions.

18. Mr H wrote again to the Chief Executive of the Trust on 22 December 2006. He said he was still concerned that the staff involved in the meeting on 21 November 2006 had maintained that Mrs J should remain in her flat, yet she was found wandering the street shortly after returning home. He reminded the

Chief Executive, too, of the issue raised in his previous letter about Mrs J's EMI status.

19. The Trust's acting Chief Executive replied to Mr H on 22 January 2007. He acknowledged that Mr H was concerned about the meeting on 21 November 2006, but said the team were aware of the risk factors involved and that a risk assessment and care plan were arranged before Mrs J's actual discharge. Turning to the EMI issue, he commented that Mrs J would already have been considered to fall within this category due to the nature of her illness; however, that did not in itself prevent those so classified from living in the community.

20. Mr H replied on 17 February 2007. He reiterated his concerns and commented that, except in emergencies, there was no one available from the nursing team, or social services, should something happen after 5.00pm.

21. Following the involvement of Mrs J's MP, the Chief Executive of the Trust replied on 21 May 2007. He apologised for the delay in doing so. He explained that the local community mental health team was actually available until 8.00pm on weekdays. He said he felt the Trust had now provided as much information as it could and that he had been assured the actions taken were appropriate in the circumstances. He provided information about how Mr H might take his complaint further if he so wished.

WHAT THE COMPLAINANT HAD TO SAY

22. In his **letter of complaint** to the Ombudsman, Mr H said that at the time of the events complained about, Mrs J had scarred lungs as a consequence of previous tuberculosis; severe osteoporosis; poor sight and hearing; had lost weight; and was very confused.

23. Mr H said the Trust had acknowledged that it may have been appropriate to have postponed the meeting on 17 October 2006, given that he was unable to

attend, but had qualified this by saying that care staff had arranged their diaries around that date. Mr H commented that this appeared to put the considerations of the staff involved above those of him as someone who had been involved in looking after Mrs J for many years.

24. Mr H said that before Mrs J went home, an alarm was installed, which, if Mrs J approached the front door at night, would play a recorded message telling her not to go outside. Mr H said he imagined this would have added to Mrs J's confusion, as she would have wondered who this "woman" was in her flat.

25. **At interview** Mr and Mrs H were accompanied by their advocate from Gwent Community Health Council ("the Advocate"). Mr H said he had been looking after Mrs J for 40 years after her husband had been left disabled by a coalmining accident. Mr H said Mrs J had suffered a number of nervous breakdowns and he had had to help look after her.

26. Mr H explained that Mrs J was a very quiet, pleasant lady; however, after she was admitted to the Home for respite care, he and other family members noticed a change in her attitude: she became belligerent towards them. Mr H said he was concerned about this, so he spoke to the manager of the care home ("the Manager"). He said the Manager told him that Mrs J had demanded to use the telephone as she wanted to ring the police to tell them she was being detained against her will. Mr H said at that moment, Mrs J appeared in the corridor with the CPN. Mr H said Mrs J shouted at him that he was trying to keep her in the Home. Mr H said he replied that he was as it was not safe for her to go back to the flat. Mr H said he believed the change in attitude was down to the CPN, and that she had "put her up to it." Mr and Mrs H said they felt the CPN's attitude was inappropriate and that she seemed to be attempting to displace the family.

27. Mr H said a couple living near Mrs J used to keep an eye on her. He said that a few days after Mrs J returned to the flat, he received a telephone call from one of them to say that Mrs J had wandered out into the street in the dark. Mr H

said he therefore asked the neighbour to pull the alarm cord in Mrs J's flat which alerted the out-of-hours ("OOH") service that there was a problem. Mr H said he was subsequently contacted by the OOH service, and explained the circumstances. He said that after about five hours, Mrs J was taken back to the Home, where she remained for the rest of her life. Mr H said he was told by the OOH CPN that Mrs J should not have been living at the flat.

28. Mr H said he felt the CPN exercised undue influence over the Consultant Psychiatrist. He said that at the meeting on 21 November 2006, the CPN and the Consultant Psychiatrist in turn seemed to influence the others present, some of whom did not actually know Mrs J. Mr H said they got the impression that they were in effect outvoted before the meeting began, and that the decision to return Mrs J home was a "fait accompli". Mr H said that at the meeting, the Consultant Psychiatrist asked the Social Worker whether Mrs J was happy at the Home. Mr H said he felt this was misleading as if you ask any old person who is living in a nursing home whether they want to return home, the vast majority will say yes. Mr H said he was more concerned about Mrs J's safety and that of the other residents of the flats, given that she would have been left on her own for 15 hours a day. Mr H said when the Consultant Psychiatrist was asked what would happen if something went wrong, he replied that they "would reflect". Mrs H said she thought this amounted to neglect. Mr H said the Manager (who had not been able to attend the meeting), later told him that if she had been present, she would have been against allowing Mrs J to go home.

29. Mrs H said that Mrs J was taken home to see the new shower by the CPN on a day when it was pouring down with rain, and there had been no heating on in the flat for weeks. They said they were not told about this visit. Mrs H said she felt the CPN was trying to "brainwash" Mrs J into agreeing to return to the flat by taking her to see the shower. Mr and Mrs H said they were concerned about Mrs J being under the care of the CPN. Mr H commented that he felt in conflict with her and she did not return his telephone calls. He said he had asked the

Chief Executive of the Trust to transfer responsibility for Mrs J's care to another nurse; however, nothing came of this request.

30. Mr H said that Mrs J's dementia came on quite quickly, within the space of about a year. He said she started to go downhill after her flat was flooded in January 2006 due to a burst pipe. Mr H said Mrs J was smoking 200 – 300 cigarettes per week, and on one occasion the home carer visited to find the carpet smouldering. Mr H said he then took Mrs J's cigarettes away. He said that when he told the CPN, she asked about withdrawal symptoms, but he said he was more concerned about the risk of fire, given there were 28 flats in the block occupied by elderly residents. Mr and Mrs H said that towards the end, Mrs J was creating a number of risks; for example she attempted to change the curtains late at night and put washing in the oven.

31. Mr H said he was not involved in many discussions with staff about Mrs J's care before October 2006. He said he got the impression they did not want him around, so he was not told what was going on. He said they were only invited to two meetings about Mrs J's care. Mr H said the first of these was in October 2006, and he was unable to attend. He said he only found out about this meeting at short notice, as the letter inviting him had been sent to Mrs J. Mr H said he had told staff not to do this as Mrs J had a tendency to throw away or hide letters.

32. Mr H said he took Mrs J to see a chest physician, ("the Consultant Physician") in June 2006. He said she was so weak that he had to get a wheelchair to take her to the appointment. He explained that Mrs J had an X-ray which revealed that she had suffered from tuberculosis at some point in the past. Mr H said the Consultant Physician told him that Mrs J was "high risk", and he therefore passed this information on to the CPN and the Social Services Department. The Advocate said it was not clear if the care team had access to the Consultant Physician's records when they were doing their assessments; and if not, whether it was possible to reach a balanced decision.

33. The Advocate said she understood the October 2006 meeting was very short – a matter of minutes – and wondered if it was sufficiently thorough. Mrs H said that she believed the 21 November 2006 meeting should have considered whether Mrs J required long term care. Mr H said staff admitted during this meeting that a lack of funds was a factor in deciding what to do. Mr H said the Consultant Psychiatrist had said at this meeting that Mrs J was not an EMI patient, yet following the wandering incident she was judged to be EMI. He could not understand how her status could have changed so quickly. Mr H said they were not involved in the discussions when Mrs J's assessments or care plans were drawn up.

34. When asked about Mrs J's mental capacity, Mr H said he felt she did not really have the ability to make decisions from June 2006. Mr H said he thought the Consultant Physician agreed with the CPN's opinion as a matter of course and this meant that the opinions of the family were overridden. Mr H said he was pursuing the complaint as he did not want other families to encounter the problems they had. He said he was concerned that similar things were happening to other people. Mr H also said that there had been a three month delay in the Chief Executive of the Trust responding to one of his complaint letters.

WHAT THE TRUST HAD TO SAY

35. In its formal comments to the Ombudsman, the Trust said that at the time, there were no written policies in place relating to the process the team followed; however, it had since introduced a unified assessment and care programme approach. It said that this clearly states that families and carers should be involved by staff. However, it commented that staff would have been expected to do this at the time, save for when it would be counter-productive to the patient's care.

36. The Trust said that Mrs J was assessed by the Consultant Psychiatrist in October 2006 as having "partial capacity to make informed decisions about her

environment and future needs". It said that it was therefore decided to go ahead with the October 2006 meeting despite Mr H's inability to attend. It said that it was also difficult to secure dates in diaries for a number of clinicians and that it understood individual clinicians had informed Mr H of the arrangements on a number of occasions. The Trust said an independent advocate had represented Mrs J's views at the meeting in November 2006. The Trust said it believed that there were concerns that Mr H had different views to Mrs J.

37. Turning to the question of whether staff had liaised with the Consultant Physician, the Trust said that once it was known that the diagnosis was that of dormant tuberculosis, and given that Mrs J's physical condition had actually improved, it was not felt there was a clinical need to consult him further. The Trust said that at the time records from different divisions were not combined (i.e. the records relating to Mrs J's consultation with the Consultant Physician were filed separately from those relating to her mental health); however, it was now working towards introducing a single patient record.

38. In terms of Mrs J's long term care needs, the Trust said that although there was no specific reference to these, the records did indicate that they had been discussed and contingency plans put in place (an entry on 13 November 2006 stated that a place at the Home would be kept open for Mrs J after she returned to the flat).

39. The Trust acknowledged that a formal risk assessment was not carried out until 20 November 2006, as it was not normal practice to do so at the time. The Trust said that there were, however, references throughout the notes to various risks being identified.

40. Turning to the standard of record keeping, the Trust said that its divisional learning group had already formally written to every member of staff to remind them of their responsibility to write clear, concise, and chronological entries in patients' health records. The Trust said this would be formally audited later in

2008, in addition to the regular audits already carried out by the divisional learning group.

41. When it was put to the Trust that Mr H's request (in his letter of 15 November 2006) for Mrs J's CPN to be changed did not appear to have been responded to, the Trust said that this point did not appear to have been raised during a meeting Mr H had with the officer who was investigating his complaint on 23 November 2006. The Trust said this officer had now retired, so it was difficult to clarify why this was. However, it said that often when its staff meet with complainants, some of the points they originally raised are addressed during the meeting and the complainant therefore decides that they do not require any further action to be taken.

WHAT THE COUNCIL HAD TO SAY

42. In its formal comments to the Ombudsman, the Council said the Social Worker could not recall Mr H specifically asking the team to seek clarification about Mrs J's physical condition from the Consultant Physician. It said that if he had, the matter would have been referred to health.

43. The Council said that the notes and care plans on file demonstrated that risks were assessed on a regular basis and changes made to minimise them. It commented that the records also showed that the professionals, and Mrs J's family and neighbours, worked together to manage the risks.

44. The Council said that all the professionals present at the meeting of 21 November 2006 had agreed that Mrs J should be enabled to return home. It said this was because measures had been put in place to minimise potential risk; because Mrs J had a good network of support from her family, neighbours, and the statutory services; and because Mrs J was not happy in the Home and wished to return to her flat. The Council said the professionals involved believed that Mrs J had the right to choose where she lived.

WHAT THE OMBUDSMAN'S PROFESSIONAL ADVISERS HAD TO SAY

45. The Ombudsman's **Nursing Adviser** said that the notes showed that Mrs J had been involved with, and consulted about, decisions relating to the delivery of her care, and although it was recognised that there was a decline in her condition, a number of options were considered and implemented with her consent in order to meet her desire to remain at home. She said the notes also highlighted engagement with Mr H about Mrs J's care.

46. The Adviser commented that as Mrs J's needs grew, there was an increase in the provision of home care to a relatively intensive package. She said that there was evidence of a reasonable approach in the monitoring of changes to Mrs J's condition, and the responses to those changes. She commented that this was evidently sometimes challenging given some of the risks associated with Mrs J, such as the incident with the microwave, and the cigarette burns. She noted that steps were taken with the agreement of Mr H to minimise these risks.

47. The Adviser noted that a Mini Mental State Examination (a test which helps show if a person has mental capacity) was done by the Consultant Psychiatrist in October 2006, which, according to the records, suggested that Mrs J was still able to make decisions about returning home.

48. The Adviser said that the CPN's actions in taking Mrs J home to show her the new shower amounted to good practice as it would have been essential to do this to help reduce the risk of Mrs J's anxiety and depression increasing. However, she said that these visits should have been clearly stated in Mrs J's care plan, and Mr H told they were going to take place.

49. The Adviser commented that cases such as this are extremely difficult as the needs and wishes of the patient cannot always be reconciled with those of their family members/carers. She said that in her experience, good

communication and co-ordination of care is essential to address these issues. She said that this not only allows for the provision of a robust plan which is fully informed by, and agreed with, the patient where possible, but also allows the opportunity to build a relationship with their family/carers so they feel confident about raising issues and gain the necessary insight into the policies and procedures in place and the reasons for making decisions.

50. The Adviser said that in general, the services involved appeared to have responded to the risks identified and introduced appropriate measures which would best meet Mrs J's needs. She felt this was reasonable and in line with good practice. The Adviser acknowledged Mr H's concerns about Mrs J's vulnerability and recognised that he was attempting to pursue what he thought was the best and safest option for Mrs J. The Adviser said, however, that the main consideration as far as the services involved were concerned was how to maintain as safe an environment as possible (albeit this can never be guaranteed) at home, as they were unable to force Mrs J to enter a care home against her wishes.

51. The Adviser said that although there was evidence to show that a reasonable attempt had been made to work with Mrs J and manage the risks of her staying at home, there was a lack of evidence available to confirm that this information was available across the disciplines involved in Mrs J's care. She said there was also a lack of evidence of partnership working that would demonstrate a robust and evidence based approach to managing her care. She said that in hindsight, it may have been beneficial to have undertaken a risk assessment at an earlier stage; however, she did not feel that Mrs J suffered because of this.

52. The Ombudsman's **Social Services Adviser** said that professional efforts to establish purposefully Mrs J's views about her longer term future did not feature significantly in the records. She felt two assumptions appeared to prevail: firstly that Mrs J had impaired mental capacity to decide where to live; and hence,

secondly, that professionals should "act in her best interests" to ensure that she remained in her home.

53. The Adviser noted that reference was made to Mrs J's impaired mental capacity in both the Trust and Council's records. She said the social services records referred to the reported statement of the Consultant Psychiatrist that Mrs J had "partial" capacity, but she could find no other assessment of Mrs J's capacity; specifically her capacity to reach an informed decision about where she lived or to understand (and accept) the potential risks of living alone.

54. The Adviser noted that an advocate was arranged for Mrs J after Mr H opposed her return home in November 2006. The Adviser said that she would expect an advocate to meet the person on whose behalf they were advocating more than once. The Adviser commented that profound decisions about where to spend the rest of one's life are not easily reached. She said that in her professional experience of social care over four decades, she could not recall a vulnerable older person rejecting the status quo when posed with alternatives such as "do you want to live in a care home or your own flat?" She said that these decisions require discussion over time with an appropriate person or persons. She said that meeting a stranger, on one occasion only, at the point of discharge home, was unlikely to enhance the likelihood of informed decision making.

55. The Adviser explained that an assessment of needs under the statutory guidance on unified assessment and care management (paragraph 6, above) requires assessment and care planning to take account of the likely progress of a person's care needs and circumstances (i.e. how identified needs and risks might change over time). She said the Guidance stated that the focus should be on the immediate and longer term in care planning and take account of risks to the person and others. The Adviser felt the Council's comments in its response to the Ombudsman (paragraph 44, above) that "the professionals involved in [Mrs J's] care believed she had the right to choose [where she lived]" belied the absence

of any dialogue over time with Mrs J about where and how her immediate and long term needs might best be met.

56. The Adviser noted that there were frequent references to risk in the files. She said, for example, that the social services records for 5 July 2006 stated that Mrs J "comes up with scenarios that place her and her neighbours at risk and for which we need to continuously devise preventative measures."

57. The Adviser noted that in November 2006 Mr H opposed Mrs J returning to her flat from respite, and observed that at that point a case conference was arranged, a risk assessment carried out, and an advocate provided for Mrs J. The Adviser said that the timing of these measures suggested somewhat defensive action on the part of the Trust and Council; that is that these arrangements were made as a result of Mr H's opposition to Mrs J returning to her flat. The Adviser said that she would have expected a thorough risk assessment and risk management plan to have been done in summer 2006, when concerns first arose about Mrs J.

58. The Adviser felt, too, that the risk assessment carried out on 15 November 2006 should have appraised more robustly the ways they proposed to mitigate, manage and minimise identified risks, and to evaluate how suitable the proposed risk reduction methods were for Mrs J. She said, for example, it was unclear how appropriate it was for Mrs J to have a vocal alarm warning her not to leave her flat at night: what was the estimated likelihood that this would deter Mrs J; what was the likelihood it might frighten and distress her; and what was the contingency plan if that happened? The Adviser commented that simply installing an alarm would not mitigate the risk without simultaneously considering the particular person at risk and how they might respond to the particular risk reduction measure. She said she could find no professional assessment in the records about how effective this strategy was likely to be in deterring Mrs J specifically (as opposed to anyone else).

59. The Adviser said that the impression she gained from the records was of various devices or actions being implemented reactively between June and November 2006 (e.g. the installation of the alarm, unplugging appliances), without sufficient proactive appraisal of anticipated risks and management during the 12 – 15 hours Mrs J was alone in her flat and her neighbours asleep, or of the effect on Mrs J's quality of life of the risk reduction methods used.

60. The Adviser said that the Council's response to the concerns that a risk assessment was carried out at a late stage (paragraph 43, above) was inadequate. She said that talking about risks is not the same as the professional formulation of a formal risk assessment and risk plan. She said that risk analysis is not just a paper exercise, rather it demands focussed attention, critical thinking and professional judgement. The Adviser said that it was neither reasonable nor appropriate to have delayed this; it should have formed a key part of care planning when concerns arose in June 2006.

61. In conclusion, the Adviser said that despite frequent references in the files to risks, a risk assessment and risk management plan were not done in June 2006 when the need arose. She said, too, that notwithstanding the many and varied references to Mrs J's mental capacity, a multi-disciplinary assessment of her specific capacity to understand the risks of staying in her home, or to decide where to live, was not apparent in the records. She said that while it was not possible to say that the decisions reached were unreasonable or inappropriate, the fact that they were made in the absence of these two key assessments was questionable. The Adviser said that what happened may still have happened, and risk can never be completely eliminated. However, she said the fact the Council and Trust did not apparently do these assessments meant it was less certain the decisions taken were both reasonable and appropriate in the circumstances.

62. The Adviser said any judgement about the appropriateness of the care given to Mrs J needed to be based on a robust assessment of needs and risks. She said that Mrs J's care plan appeared to address the main needs identified.

63. Turning to the standard of consultation with Mr H, the Adviser noted that he held an enduring Power of Attorney to deal with Mrs J's property and affairs (although this did not give powers to make decisions about her health or welfare); was next of kin; and the main family carer. She felt that as Mr H was therefore a key figure, it was neither reasonable nor appropriate for the meeting of 17 October 2006 to have gone ahead without him. Similarly, she would have expected Mr H to have been informed that it was intended to take Mrs J home to see the new shower in November 2006. Turning to the meeting between Mr and Mrs H and staff on 21 November 2006, the Adviser said it was not clear whether its purpose was to reach a measured view as to where Mrs J's long term needs might best be met (in which case it failed to meet its objective), or a meeting where Mr H could put his views directly to professionals. She said that if it was the latter, the fact there was a conflict of views was not of itself unreasonable or inappropriate.

CONCLUSIONS

64. In reaching my findings I have been guided by the advice of the Ombudsman's professional advisers. Mr H has raised concerns about the standard of care provided to Mrs J, and, in particular, that insufficient weight was given to his concerns about the risks to Mrs J (and others) when it was decided to return her to her flat in November 2006 after a period of respite care in a care home.

65. It is clear that this was a difficult situation for all concerned. The notes record that Mrs J had expressed a clear preference on a number of occasions to return home, and it was right of the staff involved to support her in that wish to the extent that it was safe to do so and Mrs J was able herself to weigh up the pros and cons of returning home. However, it is not clear what Mrs J's mental capacity at that time was. There are certainly numerous references, both in the notes, and from Mr and Mrs H's letters, to the fact that Mrs J was often "confused". A mini-

mental state examination was carried out by the Consultant Psychiatrist, but there is no contemporaneous record of the outcome of this in the clinical notes. His letter of 6 November 2006 tends to suggest that she lacked capacity; however, elsewhere she is referred to as having "partial" capacity and as being able to make decisions about where she lived.

66. We will now never know what the exact position was; however, it seems to me that there was a failure by the staff involved, either to adequately assess Mrs J's mental capacity to decide, specifically, where she lived, or, if that was done, to adequately record the outcome, and to ensure all parties involved were clear about it. I am also mindful of the Social Services Adviser's comment that such a fundamental decision needs careful discussion over time, with an appropriate person or persons. Again, this does not appear from the records to have been done.

67. Given these circumstances, it is difficult to conclude whether or not the decision to return Mrs J to her flat was reasonable. If Mrs J did have the mental capacity to make a decision about where to live, had had the risks of doing so properly explained to her, and had still expressed the wish to go home, then staff would have had no alternative in law than to do what she wanted. On the other hand, if Mrs J had been assessed as not having sufficient mental capacity to make this decision, then staff would have needed to have made a decision in her best interests on the basis of a professional assessment of the risks involved.

68. Both Advisers have also noted that a formal risk assessment was not carried out until November 2006. I agree with them that this should have been done earlier, together with a risk management plan. Had this been the case, steps might have been taken at an earlier stage to manage proactively some of the risks which became apparent between June and November 2006. Instead, it appears a reactive approach was taken with risks removed or reduced only after an incident had already occurred. Had a thorough risk assessment been done at an earlier stage (such as in June 2006), it may be that some of the incidents

which happened subsequently could have been prevented, albeit (as the advisers have pointed out) it is never possible to eliminate every risk.

69. I recognise that many of the actions taken (such as unplugging appliances) were appropriate in the circumstances; it would, however, have been better practice had these risks and actions been assessed and identified at an earlier stage. A thorough written assessment would also have shown whether staff did in fact take proper account of how the risk reduction measures could affect Mrs J's quality of life; as the Social Services Adviser has commented, it is unclear whether (for example) full consideration was given to whether the audible alarm installed in the flat could have frightened or distressed Mrs J.

70. Turning to the standard of communication with Mr H, I would agree with the Advisers that the meeting of 17 October 2006 should not have gone ahead without Mr H's participation, given his key role in Mrs J's care, and that he should – for the same reason – have been made aware of the plan to take her home to view the shower. I welcome the fact that the Trust has already apologised to Mr H on these points. I should also say that I do not believe the decision to take Mrs J to see the shower was unreasonable; as the Nursing Adviser has pointed out, it was a way of keeping her aware of what was happening, and of reducing the risk of an increase in her anxiety and depression while at the Home.

71. In conclusion, I am critical of the fact that a formally documented risk assessment and risk management plan were not drawn up at an earlier stage, and of the fact that the assessment (or at the very least recording) of Mrs J's mental capacity to make a decision about where she lived was inadequate. To that extent I uphold the complaint.

RECOMMENDATIONS

72. I recommend that:

1. The Trust and Council apologise to Mr H for the failings identified in this report;

2. the Trust and Council remind relevant staff of the importance of carrying out a documented formal risk assessment at an early stage in future cases, in order to identify and manage the risks to the service user and others; and

3. the Trust and Council remind their staff of the importance of fully recording a formal assessment of a person's mental capacity to make the decision in question.

The Trust and the Council have seen a draft of this report and have agreed to implement the recommendations listed above.

Greg Phillips
Investigator

4 September 2008

Signed under the authority delegated to me by the Ombudsman

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