The Commission for Local Administration in England

Parliamentary and Health Service Ombudsman

Injustice in residential care: A joint report by the Local Government Ombudsman and the Health Service Ombudsman for England

HC 421

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Injustice in residential care: A joint report by the Local Government Ombudsman and the Health Service Ombudsman for England

Investigations into complaints against Buckinghamshire County Council and against Oxfordshire & Buckinghamshire Mental Health Partnership

Second report

Session 2007-2008
Presented to Parliament pursuant to
Section 14(4) of the Health Service Commissioners
Act 1993 (as amended)

Ordered by
The House of Commons
to be printed on
26 March 2008

HC 421
London: The Stationery Office
£13.90

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Foreword

I am laying before Parliament, under section 14(4) of the Health Service Commissioners Act 1993 (as amended), this joint report of the investigations into complaints made to the Local Government Ombudsman for England and to me as Health Service Ombudsman for England against Buckinghamshire County Council and Oxfordshire & Buckinghamshire Mental Health Partnership NHS Trust respectively. The complaints were made by Mr and Mrs Taylor* about the care provided to their son, Frank, an adult with severe learning disabilities. Our investigations found that there had been maladministration by both the Council and the Trust which resulted in unremedied injustice for Frank and his parents. The report details the remedy we have recommended to the Council and the Trust.

This is the first joint report I have produced with the Local Government Ombudsman using our new powers under the Regulatory Reform (Collaboration etc. between Ombudsmen) Order 2007. The Order marked a major step forward for our Offices, and has enabled us to work together more effectively in investigating and reporting on complaints which cross our respective jurisdictions. Had the Order been in force when we first received the complaints from Mr and Mrs Taylor, we could immediately have initiated a joint investigation: that might have resulted in a faster resolution of the complaint for Mr and Mrs Taylor, and Frank.

Nevertheless, having the statutory power to issue a joint report of our investigations into Mr and Mrs Taylor's complaints has been invaluable in ensuring that the Local Government Ombudsman and I have been able to consider maladministration, and any resulting injustice, in the round. This, in turn, has allowed us to focus on recommending a remedy in the round, which reflects the injustice experienced by Mr and Mrs Taylor and their son, rather than the constraints imposed by jurisdictional boundaries and different complaints procedures. This demonstrates the significant value of the Order in allowing us to investigate complaints, simply and efficiently, from people who are dissatisfied with public services – including the increasing number of services which are provided by several public bodies acting in partnership.

Ann Abraham
Parliamentary and Health Service Ombudsman

March 2008

* The names of the complainants and their son have been changed for the purposes of this report to protect their anonymity.

Report summary

The complaint

Mr and Mrs Taylor complained to the Ombudsmen about the care their son Frank received from the Oxfordshire & Buckinghamshire Mental Health Partnership Trust (the Trust)[1] and thereafter Buckinghamshire County Council (the Council) from June 2001 to September 2003. The names used in this report have been changed to protect the anonymity of the complainants.

During the period Mr and Mrs Taylor have complained about, Frank lived in a residential Care Home which was being run by the Trust before it entered into a section 31 agreement[2] with the Council to work together in order to provide services to those in need of health and social care. Under the agreement responsibility for the day-to-day running and management of the Care Home passed from the Trust to the Council. Frank has a need for a residential care setting as he is an adult with severe learning disabilities. He has no speech; cannot bathe, shave or dress himself; needs assistance to go to the toilet; and needs to wear incontinence pads at night, or for any lengthy periods spent outdoors. He needs one-to-one attention for about 95% of his waking time.

Whilst he was residing at the Care Home Frank's care needs were never properly assessed, and a number of significant failings in respect of the level of care he received were identified. Although Frank's parents voiced their concerns to the Trust and the Council there was both delay in responding to these concerns, and a great deal of confusion as to which body should address the separate aspects of the complaint. Whilst at home during the Christmas 2002 break Frank suffered from anxiety and depression and refused to leave the house. His parents feel that was because he had a fear of returning to the Care Home. They accommodated Frank at home without any external support until March 2003, when Frank was returned to the Council's care. When Frank's needs were finally assessed, and a Care Plan prepared, he was moved to a residential home which provided the level of care and support that an adult with his complex needs required, although Frank has since moved from that home.

[1] During the period covering the events discussed in this report the predecessor Trust was known as Buckinghamshire Mental Health NHS Trust.

[2] An agreement made under section 31 of the Health Act 1999.

Our investigations and report

Although we have separate jurisdictions over different parts of the complaints, we felt that it was in the best interests of the complainants and their son to have a single point of reference for their separate complaints to each Ombudsman. Many aspects of the health and social care complaints are inextricably linked and we have concluded that our separate investigations, conclusions and proposed remedy are best represented in a joint report. This is the first such report we have issued under the Regulatory Reform (Collaboration etc between Ombudsmen) Order 2007 which enables us to conduct joint investigations and to report jointly about matters which would previously have been dealt with separately by the individual Ombudsmen.

The delivery of a service through a section 31 agreement poses interesting and difficult questions about public bodies working in partnership. We are particularly concerned to ensure that robust and transparent governance arrangements are in place, in order to provide clear accountability for the actions of authorities. In this way, a complainant can be more readily signposted to the body that can better deal with a complaint.

We are also concerned that all recipients of health and social care – irrespective of their vulnerability – and their relatives or others concerned about their care, should have their human rights taken into account when plans and provision are made. Given the events which transpired in respect of Frank's care, we specifically asked both the Council and the Trust how they had ensured that this was the case. In response the Trust acknowledged that there appear to have been lapses in its predecessor's consideration and maintenance of Frank's human rights, and that the result of this was that the care and treatment delivered was below an acceptable standard. The Council has said that the home, in which Frank and other residents had been living for years, did little to ensure their right to privacy and family life, although at the time of taking responsibility it was not aware of the extent of the problem.

Findings

Maladministration causing injustice. We find that during his time in the Care Home Frank's care needs were never properly assessed and the level of care he received was below that which he and his parents were entitled to expect. In addition, we find that Mr and Mrs Taylor were wrongly charged for items which should have been paid for from Frank's funding. We also find that, as a result of the inability of both the Council and the Trust to respond appropriately to their concerns, Frank's parents were caused a great deal of anxiety and distress in attempting to care for him for a period of three months at home without any external support, as they did not feel that he could return to the Care Home about which they were so concerned.

Throughout the period complained about agreement could not be reached about who should take responsibility for Frank. This dispute was not resolved until, after extensive searches, the Council moved Frank to an out-of-County placement. The Council has said that although it should have been aware of the prevailing conditions within the Care Home when it entered into the agreement, it was only when it took over the management functions that the true extent of the problem came to its attention. Thereafter, it took the unilateral decision to place Frank in a more appropriate care setting commensurate with his needs which has resulted in it being responsible for the costs of his care, whereas they were previously being met exclusively by the Trust. The Council has said that it took this decision with Frank's best interests in mind. Whilst the Trust was maladministrative in allowing the Care Home to deteriorate to the condition that it was in when the transfer of management took place, the Council's failure to properly apprise itself of those conditions when agreeing to take over responsibility for managing and delivering appropriate care to its residents, also amounts to maladministration.

In terms of Frank's human rights it would be for the courts to determine whether there has been a breach of the Human Rights Act 1998 and if so to make binding declarations and decisions. We have considered whether relevant issues were engaged in Frank's case and whether they were properly taken into account in a timely way by the Council and the Trust. We have concluded that Article 3 (which includes inhuman or degrading treatment), Article 8 (which

includes the right to respect for private and family life and home) and Article 14 (prohibition of discrimination) were engaged in Frank's case, and that the Council and the Trust both neglected to give those issues proper or timely consideration. Not all the relevant issues were properly taken into account in Frank's case (nor, evidently, in the case of other residents in the home). This failure was so significant as also to amount to maladministration and contributed to the injustice suffered by both Frank and his parents. A proper consideration of human rights issues at any point would have led to improvements in Frank's and his parents' situation.

The Health Service Ombudsman found that whilst Frank was under the care of Trust staff the diagnosis of autistic spectrum disorder had not been firmly established and the diagnosis of bipolar affective disorder was provisional and made in the absence of other confirmation. The Health Service Ombudsman found that the records on this point do not seem entirely accurate, which is maladministrative, but she nevertheless concludes that no significant injustice has resulted. Therefore, although she finds that there was maladministration in respect of the recording (particularly in respect of references to autism) she does not uphold this aspect of Mr and Mrs Taylor's complaint. She concluded that the prescription of several medications in combination was not inappropriate and did not itself amount to a failure in the service provided to Frank. However, she noted that the monitoring of the medication should have been better, and she took that into account when considering the more general concerns about the care provided.

Remedy

Both the Council and the Trust have accepted that the conditions within the Care Home at the time of the events about which Mr and Mrs Taylor have complained were unacceptable. This undoubtedly had an adverse effect on both Frank and his family. The Council has said that when it became aware of the true extent of the problems within the Care Home it could have cancelled the agreement to take over its management. It elected not to do so as it felt that this would do little to assist those who were living in the Care Home. Although the Ombudsmen are mindful of this, neither that nor the decision to move Frank to a more appropriate care

setting has provided a full remedy for Frank or his parents for the injustice they were caused prior to his move.

We recommend that a payment of £32,000 is made. In determining this sum we considered the injustices identified:

- The expenses that Mr and Mrs Taylor paid out unnecessarily while Frank was resident in the Care Home (although they estimate this to be £20,000 in total, it is not now possible to substantiate that this total is comprised exclusively of costs that should have been met by the Care Home. We concluded that a more reasonable sum, in respect of the expenses unnecessarily incurred directly by Mr and Mrs Taylor, is just in excess of £10,000).

- The acute anxiety and distress Frank and his parents must have experienced as a result of the poor standards of care he received whilst he was resident in the Care Home.

- Mr and Mrs Taylor's efforts in physically looking after him without any external help or support from December 2002 to March 2003 during which time the Care Home was being run and managed by the Council, and the costs that they incurred during this time.

- The distress that the whole episode has caused to Frank, Mr and Mrs Taylor and Frank's siblings which the Council accepts was compounded by its failure to deal with their initial complaint of September 2002 in an appropriate or timely fashion.

We therefore recommend that the Trust and the Council each make a payment of £16,000. We leave it to Mr and Mrs Taylor to decide how best to use this payment.

The Council has questioned why it should be asked to pay £16,000 since it was not responsible for the expenses unnecessarily incurred by Mr and Mrs Taylor, and the conditions within the home remained the same throughout the period complained about: when both it and the Trust were responsible for its day-to-day management for equal periods of time. It has suggested that the Trust be asked to reimburse the £10,000 expenses, and that the

remaining £22,000 compensation be shared equally: it has said that it cannot understand the rationale for asking the Trust to pay £6,000 and the Council £16,000 for what amounted to the same fault – the poor standards of care Frank received whilst being accommodated within the Care Home.

We consider that it is reasonable to ask the Council to pay £16,000 as it was responsible for the day-to-day management of the Care Home at the time when particularly serious injustice occurred. This included the three-month period when Frank was being accommodated at home without support, and the costs Mr and Mrs Taylor incurred during this time, as well as the distress and anxiety caused to them. It must also recognise that its failure to deal with their complaints in accordance with the statutory timescales in place at that time further frustrated their attempts to ensure that Frank relocated to a more appropriate care setting as soon as was possible following their initial request that this was done, in September 2002.

Matters considered solely by the Health Service Ombudsman

In addition to the matters considered by both Ombudsmen, Mr and Mrs Taylor were concerned about two matters which relate specifically to the exercise of clinical judgment and which therefore fall to the Health Service Ombudsman to consider: diagnoses entered in Frank's clinical records; and the prescription of certain medication. The Health Service Ombudsman found that entries in Frank's records relating to two particular diagnoses had no robust evidential basis (see paragraphs 67 to 71). However, she concluded that no significant injustice has resulted from these entries in the records. She therefore makes no recommendation on this point, but points out to Mr and Mrs Taylor that it is open to them to ask the Trust to contact the current holders of the records and arrange for a note to be added to that effect. On Mr and Mrs Taylor's concerns about the prescription of particular drugs, the Health Service Ombudsman found that they had been prescribed appropriately, and so she concluded that there was not a failure in service in this respect. However, she noted that subsequent monitoring of the medication was not carried out as it should have been, and so contributed to the general poor level of service provided to Frank.

Introduction

1 From 1995 to 2001 Frank lived in what was referred to as a small staffed care home where he was both happy and settled. Frank has a need for a residential care setting as he is an adult with severe learning disabilities. He has no speech; cannot bathe, shave or dress himself; needs assistance to go to the toilet; and needs to wear incontinence pads at night, or for any lengthy periods spent outdoors. He needs one-to-one attention for about 95% of his waking time. In June 2001 he was moved to a similar home (hereafter referred to as 'the Care Home') in the same street. Mr and Mrs Taylor were not told about this move until after it had taken place. Their complaint to the Local Government Ombudsman and the Health Service Ombudsman concerned the level of care Frank was provided with from the date of this move.

2 Until July 2002 the Care Home was run and managed wholly by the Trust. The Council was responsible for providing day services for Frank, which involved regular attendance at a Day Centre where he had his lunch and undertook a number of different activities. The Trust then signed an agreement[3] (hereafter referred to as 'the agreement') with the Council whereby the responsibility for the Care Home – as well as a number of other small staffed care homes run by the Trust – passed to the Council.

3 In May 2002, some ten months after Frank had moved into the Care Home, an employee of the Trust (Ms A) carried out an investigation into the operation of the Trust's small staffed care homes as part of an ongoing internal audit process.[4] Ms A's report, which included in its remit the home that Frank lived in, contained many serious criticisms of the inadequacy of the fixtures and fittings, the decoration, staff training and supervision, and the absence of overall standards or quality assurance systems. The report concluded:

> *'The concerns raised in this report call into question the prevention and protection of vulnerable adults from physical, psychological and emotional abuse.'*

4 A copy of Ms A's report was sent to the Trust's Director of Learning Disabilities (the Director). He commented that there was much work to be done to ensure that the current residents had adequate lifestyles; he said that a full review was needed urgently. He suggested that the proposed new 'Partnership' organisation – which referred to the future sharing of responsibilities between the Trust and the Council – ought to make immediate plans to do this. The Director's report was sent to the Council the following month (June 2002). However, the Council has advised that although the report was received it was never passed up to senior officers or members involved in taking the decision to enter into the agreement.

5 Having finally been agreed on both sides a few days earlier, on 1 July 2002 the agreement came into effect. Under the terms of the agreement the Council undertook to provide services to care home residents on behalf of the Trust, including accommodation, care and assessment and treatment of care home residents, as well as the day and community

[3] An agreement made under section 31 of the Health Act 1999 to delegate provider tasks in order to provide services to those in need of health and social care.

[4] South Buckinghamshire Homes Learning Disability Services Quality Audit (Draft Interim Report) May 2002.

services provided for the residents. The Council has said that it assumed day-to-day managerial control only from 1 September 2002; although, in the Trust's view, the Council took over both funding and managerial responsibility from July 2002.

6 From about February 2002 Mr and Mrs Taylor had begun to have concerns about Frank's clinical and social care. When he came home for visits they found that his behaviour had deteriorated badly: although he was usually a very gentle person he began to hit his mother in displays of unhappiness. Mr and Mrs Taylor attributed this to his new environment. Frank had got on well with the staff at the previous home, and although his parents had been told that he would be treated in the same way at the new home, they felt that the staff there had less time for him and he did not get the same level of care and attention that he had had previously.

7 In May 2002 Frank's consultant psychiatrist diagnosed depression and prescribed paroxetine (a drug to treat depression which selectively inhibits the uptake of serotonin). Mr and Mrs Taylor say that a week or so later, when they went to collect Frank, staff said that they had advised the consultant psychiatrist that Frank was *'high'*. The paroxetine was stopped immediately and Mr and Mrs Taylor and Frank had *'an awful weekend'* while Frank *'underwent a traumatic withdrawal'*. In August and September Mr and Mrs Taylor were concerned that Frank appeared to be over-sedated. His mood and behaviour did not improve and in September 2002, having already asked during a meeting with the manager of the Council's 'small homes' that he be moved, they wrote a lengthy letter complaining that:

- Frank was moved from one home to another in June 2001 without their knowledge, and his needs for company and a limited social life were being ignored;
- they were subsidising Frank's care by paying for clothing, soft furnishings, day care activities, lunches, recreation and snacks;
- they had to pay for paint to decorate Frank's room when he first moved and he had to wait for months for a new floor covering;
- Mr Taylor had had to repair curtains in Frank's room;
- Frank's clothing was not looked after, and he sometimes wore other residents' clothes;
- staff did not have any commitment to Frank's care: by way of example, his dental health had been neglected;
- because Frank had no speech he was especially vulnerable, but staff who were providing cover overnight locked their own bedrooms. Mr and Mrs Taylor had therefore become very concerned for his safety;
- staff had talked about, or behaved towards, residents inappropriately and one member of staff had demonstrated to them how she had had to bang on a table to prevent Frank falling asleep when he was heavily sedated in order that he would stay awake and be able to sleep at night;
- on a recent occasion when they had collected Frank from the Care Home they had found him sitting in a chair near a

door; he was cold and clammy to the touch, was unwashed, unshaven and had dirty teeth. Some time that morning he had clearly had an *'accident'* and he and his clothes were covered in faeces and urine. Mrs Taylor could find no soap in the bathroom and had to go to Frank's room to get soap and clean clothes. The member of staff on duty offered no explanation, apology or help.

8 Mr and Mrs Taylor added to their complaint in late September 2002, when they learned of an incident when the driver who usually took Frank to a day centre came to collect him from the Care Home but could not find a member of staff present and had to take him away without anyone knowing that he had gone.

Legal and administrative background

9 Social services authorities have a statutory duty to assess the needs of any person who appears to them to need 'community care services' and to decide in the light of the assessment whether services should be provided for that person.[5] A care plan should then be drawn up and reviewed annually.

10 In addition, the Department of Health have issued guidance to social services authorities specifically on the planning and delivery of social care to those with learning disabilities. Such services should be planned on an individual basis taking account of age, needs, degree of disability and the preferences of the individual and his or her parents; parents should be fully informed about decisions about the services to be arranged; and authorities should recognise the legitimate anxieties of parents about the continuity of service for those whose severe learning disabilities mean that they will need support throughout their lives.[6]

11 When residential accommodation is provided, authorities need regularly to assess and review each individual and plan a package of services aimed at ensuring that he or she receives any supporting services in a setting which offers the most scope for individual development and wellbeing.[7]

12 Social services authorities also have a duty to provide a complaints procedure under the NHS and Community Care Act 1990. They must follow a three stage process: Stage 1 – informal resolution; Stage 2 – formal investigation; and Stage 3 – Complaint Review Panel. At the time of these events there was a 28-day time target for each stage, but this could be extended to three months for Stage 2. A council has 28 days to decide whether to accept Panel recommendations. The Council may decide not to do so, but must give sustainable reasons.

13 In March 2001 the Government issued a White Paper[8] which set out its vision of the future for people with learning disabilities. It had at its centre four key strategic elements of Rights, Independence, Choice and Inclusion and envisaged that each individual would have a comprehensive, multi-disciplinary assessment of their needs, called 'Person-Centred Planning'. The White Paper envisaged the development of alternative settings for services then being provided in long-stay hospitals, large hostels and day centres. This 'reprovision programme' would provide replacement community-based services, meeting new standards. The White Paper has never been enacted. However, the Council has advised that the aim of the proposed 'reprovision programme' of replacing long-stay hospitals, large hostels and day centres with community care services meeting new standards has been achieved in its area, and has said that this could not have been so without the agreement.

14 The agreement between the Council and the Trust set out the future arrangements for the local provision of learning disability services. Paragraph 2.1 of the agreement states:

> *'The Council shall exercise the statutory functions of the Council, the PCTs, and the Trust ... in relation to those members of their communities requiring Learning*

[5] NHS and Community Care Act 1990, section 47(1)(a).
[6] Local Authority Circular (92)15.
[7] Ibid.
[8] Valuing People: A new strategy for learning disability for the 21st century.

Disability and Services. This shall include … the provision of accommodation and care [and] *the provision of assessment and treatment …'*

Paragraph 2.6 explains further that:

'For the purposes of this Agreement the Council will act as Lead Provider for the Services, and the functions of the Trust and the PCTs will be delegated to the Council to the extent necessary to enable the Council to perform this function.'

Paragraph 5.1 states:

'The parties agree to provide the financial resources to the partnership as detailed in the budgets outlined …'

15 With regard to complaints, paragraph 11.5 of the agreement says that complaints about the services provided under the agreement should be dealt with in accordance with the Council's statutory complaints procedure. However, paragraph 11.5.1 goes on to say that complaints related to matters wholly within the statutory or professional responsibilities of the Trust, and which are not resolved locally, should be dealt with under the Trust's complaints procedure[9].

16 The Human Rights Act 1998 incorporates into UK law the rights and freedoms guaranteed by the European Convention on Human Rights. Public authorities have a duty under the Human Rights Act to ensure that their actions are compatible with the principles of the Act.

[9] Frank was a recipient of both health services and social care. His parents' complaints encompassed both of these.

Investigation

17 Before approaching the Local Government Ombudsman, and then the Health Service Ombudsman, Mr and Mrs Taylor had raised their concerns with the Council through the statutory social services complaints procedure. As part of its consideration of the complaint, the Council liaised with the Trust.

The Council's handling of Mr and Mrs Taylor's complaints and its findings and conclusions

18 Having been unable to resolve Mr and Mrs Taylor's complaint at Stage 1 the Council appointed Ms A, as an independent Investigator, to report on the complaints under Stage 2 of the statutory social services complaints procedure. At that time the procedure required complaints to be dealt with through the whole of the process within a maximum period of about six months.[10]

19 Ms A had a unique insight into the prevailing conditions within the Care Home, as she had previously written a report commissioned by the Trust on the operation of all the small staffed homes, including the one Frank lived in, whilst she was an employee of the NHS (paragraph 3).

20 After they had raised their complaint Mr and Mrs Taylor met Ms A twice: first to discuss their complaint; and then, in December 2002, so that she could tell them of some of her findings. Amongst other things, she told them that there had been an incident of sexual abuse at the Care Home and she said that she had discovered that staff were locking their own doors at night to protect themselves from a particular resident's sexually deviant behaviour. Ms A told Mr and Mrs Taylor that she had raised some of their concerns directly with staff at the Care Home when she had interviewed them as part of her investigation. Mr and Mrs Taylor were very concerned about this, as they were worried that Frank might meet with reprisals from members of staff who felt they were being criticised. Mr and Mrs Taylor remained anxious about Frank's wellbeing because the Council did not put in place any additional safeguards, even when they later reported an episode when Frank had been bleeding from the rectum.[11] Taken together, all this greatly heightened Mr and Mrs Taylor's fears for their son's safety and wellbeing at the Care Home.

21 On 22 December 2002 Mr and Mrs Taylor took Frank home for Christmas. During this period he was increasingly upset, refusing to leave the house or put on outdoor clothes and hitting out at his parents. Eventually, Mr and Mrs Taylor had to call out a GP who prescribed medication for panic attacks and depression.

22 Frank remained at his parents' home, receiving no external services, until March 2003. In the meantime, in January 2003, Mr and Mrs Taylor wrote to the Council about their concerns and repeated their request that the Council secure appropriate care for their son. They also complained about delay in Ms A completing her report.

23 On 31 January 2003 the Senior Manager of the Council's Learning Disability Service wrote to Mr and Mrs Taylor, saying that it had been agreed with the relevant Primary Care Trust (the PCT) that they would jointly fund a placement

[10] Section 7B(3) Local Authority Social Services Act 1970 and the Complaints Procedure Directions 1990.

[11] Frank was assessed by his GP, who found no obvious signs of sexual abuse (such as bruising or tearing) but could not rule it out. No action was taken following this episode.

for Frank in the county in which Mr and Mrs Taylor lived; however, in the meantime, it was essential that Frank return to the Care Home. The Manager assured Mr and Mrs Taylor that the safety issues they had raised had been dealt with, and that the Care Home would provide the best service possible for Frank. He also advised that the Stage 2 report would be produced by 7 February 2003.

24 On 6 February 2003 the Council wrote to Mr Taylor, explaining that Frank needed to return to the Care Home to ensure that the PCT retained responsibility for his care; the longer he remained out of the area, the greater the risk of that responsibility being discharged.

25 By the end of February 2003 Ms A had still not produced her report, and so on 1 March 2003 Mr and Mrs Taylor complained to the Local Government Ombudsman. One of the Local Government Ombudsman's Investigators contacted the Council and was told that due to Ms A's inability to complete the Stage 2 report as a result of ill health, another Officer (Ms B) had been appointed to report on the complaint and had arranged to see Mr and Mrs Taylor on 19 March 2003. In view of this the Local Government Ombudsman decided that the complaint should proceed through the statutory complaints procedure and asked the Council to ensure that the matter was expedited, with the proviso that Mr and Mrs Taylor could refer the matter back to him if they remained dissatisfied at the end of the process.

26 In the meantime, on 24 March 2003, whilst still living with his parents, Frank began attending the day centre again. However, on 26 March 2003 he had a severe panic attack on his way back home from the centre, and was admitted to a Council-managed home on an emergency basis that evening. Mr and Mrs Taylor say that during the period that Frank had been looked after at home by them (December 2002 to March 2003), a combination of their care and medication prescribed by the GP helped Frank to recover from the depth of depressive illness. However, following the panic attack they were unable to drive him home – his disabilities preventing him from understanding their intentions – and they therefore took up this emergency offer of a room which, Mr and Mrs Taylor pointed out, had been used as a storeroom until then.

27 On 9 April 2003 Frank was moved back to a room in the home that he had vacated in June 2001. Mr and Mrs Taylor say that this, too, had been a storeroom; it was dirty and contained some broken furniture, and a resident was making inadequate attempts to clean it up.[12]

28 Ms B's report was issued on 15 April 2003; it identified 14 separate complaints:

a) Excessive and inappropriate use was made of drugs to sedate Frank while he was living at the Care Home.

b) The staff at the Care Home maintained a very poor standard of hygiene both for Frank personally and generally within the Care Home environment.

[12] The Council accepts that the service offered to Frank between 26 March and 5 September 2003 was not of the quality and standard that it would expect but has explained that at the time of this placement it was the only service available in the locality. The Council was at this time actively looking for a longer-term placement and the decision to offer the interim local service was informed in part by the fact that Frank knew the home as he had lived there before.

c) Staff at the Care Home gave Frank inadequate personal care, including lack of teeth cleaning, hair care, washing and clothes care.

d) Staff at the Care Home were not available to Frank during the night because they locked their bedroom doors.

e) The manager of a day centre which Frank attended had failed at the time to report instances when Frank was too sedated to go riding, he was found alone at the Care Home and he arrived at the day centre with wet or dirty clothing.

f) There was no comprehensive assessment of Frank's needs.

g) There was no care plan identifying how Frank's needs were to be met.

h) There were inadequate and late reviews of the service provided to Frank.

i) Mr and Mrs Taylor were inappropriately asked to fund many aspects of Frank's care and support, including furnishing for his room, clothes, his holiday, riding, meals at the day centre and his tuck.

j) No suitable alternative placement was found for Frank after his parents felt that it became impossible for him to remain at the Care Home.

k) Mr and Mrs Taylor were left without support for Frank and had to provide him with 24-hour care from December 2002.[13]

l) Their complaint made in September 2002 was not resolved.

m) The complaints officer did not keep them informed about what was happening.

n) The actions of Ms A during her initial Stage 2 investigation had made the situation worse for Frank at the Care Home, in that there were no case conferences or reviews after she had visited the Care Home and talked to staff.

29 All complaints were upheld and 30 recommendations were made, including many aimed at improving practice at the Care Home (and others like it); a number were aimed at putting right what had gone wrong for Frank and his parents. In addition to those recommendations, following the assessment of the individual complaints in the report Ms B also recommended that an independent and experienced long-term advocate be appointed with the role of ensuring that Frank's person-centred plan was implemented and monitored effectively;[14] that Frank should be given a holiday once he had settled into a new placement; and, finally, that he should be referred to a local community psychologist with a view to working with him and his care staff in future to develop strategies for managing his anger and hurt.

[13] Mr and Mrs Taylor kept Frank at home from December 2002 to March 2003.

[14] Mr and Mrs Taylor have pointed out that the Council has not been able to appoint an advocate. They themselves had referred Frank to a voluntary agency and he had received a limited service for a few months. However, when Frank moved to a new placement in March 2007 this relationship became unsustainable in the longer term.

30 On 22 April 2003 the Council's Head of Learning Disability, Mental Health and Commissioning provided a formal response on the report to Mr and Mrs Taylor, with comments on the recommendations and a timescale for the actions proposed. A Review Panel hearing was then held on 10 June 2003, and the Council accepted all of the recommendations contained in the report. On 18 June the Director of Adult Social Care advised Mr and Mrs Taylor:

> *'I have read the findings of the Panel and accept* [them] *as they relate to the service provided by* [the Council] *and am extremely concerned about all the issues raised ...*
>
> *'I will be asking the Head of Service to ensure, as a matter of urgency, that a Person Centred Plan be put in place and that she monitors the position to ensure that* [Frank] *has a service appropriate for his needs. I will agree a timescale for this with the relevant officers and ensure it is communicated to you.*
>
> *'I can assure you that I am conducting a review of how we deal with complaints ... as I am very concerned that not only did you and Frank not receive the service you should expect, your distress was compounded by the way your complaint was dealt with. I am also keen to ensure that we learn lessons as a result of the issues you raised.*
>
> *'On behalf of* [the Council]*, I offer my sincere apologies both to you and to Frank ... I will be discussing with my officers an offer of compensation in relation to the failures in my service ...'*

31 The Council's commitment to follow through the recommendations in the report included the establishment of an 'Operational Work Plan' for its Small Homes Service which contained 14 'service outcomes' or aims which were to be achieved by the provision of such things as training, specific qualifications, the introduction of policy and procedure manuals, person-centred planning and so on.

The Trust's handling of Mr and Mrs Taylor's complaints and its findings and conclusions

32 There is evidence, in the form of emails, that the Council contacted the Trust about Mr and Mrs Taylor's complaint in April 2003 after the Local Government Ombudsman had become involved and prior to the issue of Ms B's report. The Council shared Ms B's report with the Trust immediately, and there was another exchange of emails between the Council and the Trust around 15 to 16 April 2003 relating to the reimbursement of monies that Mr and Mrs Taylor should not have had to pay, which the report had estimated amounted to £19,550 in total. In her letter of 22 April 2003 the Council's Head of Learning Disability, Mental Health and Commissioning subsequently advised Mr and Mrs Taylor that the Council would ask the Trust to consider this matter, as it had held the budgets during the relevant period.

33 On 7 May 2003 a meeting was held between Council and Trust staff. An undated, unsigned confidential Trust note relating to that meeting says:

> *'A complaint was made to* [the Council] *in September 2002 regarding clinical and social care issues ...* [relating to Frank]. *The*

complaint was dealt with by Social Services and was upheld. It was only recently brought to the attention of the Trust when we were asked to make an ex-gratia payment to the family as reimbursement of monies they allegedly had been asked to pay in relation to their son's care.

'A meeting was held with social services representatives on 7 May where it was established that [Ms B] *was not qualified to investigate the clinical allegations but that the findings of the report had been accepted.*

'... The Trust is of the view that the clinical components have not been thoroughly investigated. Now that it has been brought to our attention it has been agreed that these issues will be progressed ... It was further agreed to consider reimbursement of expenditure inappropriately incurred by the family after the Trust had [sic] *completed its investigation ...'*

34 In June 2003 the Trust's Head of Clinical Governance met Mr and Mrs Taylor and it was agreed that the Trust would investigate their concerns: that drugs had been used excessively to sedate Frank; staff had maintained a poor standard of hygiene for him (and within the Care Home environment generally); he had received inadequate personal care; and staff had not been available to him at night as they had locked their doors. The Trust also said it would offer an opinion on Mr and Mrs Taylor's concerns that there had been no comprehensive assessment of Frank's needs and that they had had to fund many aspects of Frank's care – including furnishing his room and paying for his clothes, holidays, horse riding and meals at a day centre.

35 On 14 October 2003 the Trust's Interim Chief Executive provided a substantive response to Mr and Mrs Taylor, apologising for the time it had taken to do so. She concluded that Frank's medication had been appropriate; there was evidence that he had had personal care but it was not possible to say whether this was of a standard that Mr and Mrs Taylor would have wished; there was a failure to ensure that the Care Home environment was kept clean and well maintained; staff had locked their doors at night, but there was no clear protocol for this and no clear means to enable clients to contact staff should they have needed to.[15] The Interim Chief Executive said that this had now been rectified.

36 With regard to the costs that Mr and Mrs Taylor had incurred, the Interim Chief Executive said that it had been agreed at the meeting on 7 May 2003 that the Trust would give consideration to reimbursement in full for payments for which Mr and Mrs Taylor had receipts. She went on to say:

'I would normally expect that you would not have incurred costs for Frank's care while he was in NHS residential care in the following areas:

[15] Ms B found that three of the six staff who provided cover at night had been in the habit of locking their doors. This was occurring because one of the residents (who had a history of sexually deviant behaviour) was reported to take his clothes off and stand naked by the staff room door. It was subsequently reported that this resident had now been moved to another home. An investigation by the Trust in September 2003 found that two of the six staff who undertook night duty had locked their doors.

- *Furnishing for Frank's room which was essential.*

- *The NHS provides funding towards clothing for residents within its care. This funding allows minimum quantities of clothing to be purchased on a regular basis. Anything additional from the basics would be negotiated between care staff and relatives ...*

- *Regarding a holiday, it would be normal practice for the NHS to fund all reasonable costs associated with a holiday. Any deviation from this would normally be discussed with the client and the family concerned so that any additional costs would be considered and agreed prior to the holiday.*

- *Meals at the day centre and activities would not normally be attributable to you as Frank was receiving NHS continuing care at that time. ...'*

37 On 20 October 2003 Mr and Mrs Taylor wrote to the Trust that they were dissatisfied with the Interim Chief Executive's letter and they requested an independent review (IR) under the NHS complaints procedure. On 18 December 2003 the Trust's Complaints Manager advised Mr and Mrs Taylor that the Trust had approached the National Health Service Litigation Authority (the NHSLA) with regard to a decision on reimbursement, and on 23 December the Trust wrote to Mr and Mrs Taylor offering the sum of £6,000:[16]

'as full reimbursement and settlement for monies you or any member of your family paid out for lunches, horse riding and tuck for Frank ... The £6,000 ... does not cover reimbursement for any other costs such as toiletries, clothes, paint, room furnishings, holidays and continence pads.'

38 On 28 March 2004 Mr and Mrs Taylor formally declined this offer, and on 31 March 2004 the Trust advised them that it was awaiting the decision about Mr and Mrs Taylor's request for an IR before continuing discussion on any outstanding monies in addition to the £6,000 already offered. On 17 August 2004 the Trust's Convener wrote to Mr and Mrs Taylor in response to their request for an IR. She advised that her clinical assessor was of the opinion that Frank's medication had been appropriate, but that there should have been better monitoring of it and she was referring this back to the Trust for further local resolution. With regard to the remaining complaints she noted failures, which had been recognised in the Interim Chief Executive's letter, and said that the Trust should advise Mr and Mrs Taylor of changes that had been made as a result. Mr and Mrs Taylor were dissatisfied with the Convener's decision, and re-requested an IR. On 22 October the Convener wrote to them saying that an IR panel would *'simply be going over ground the Trust has already covered with you'*. She therefore declined to convene an IR. Mr and Mrs Taylor subsequently approached the Health Service Ombudsman about their complaints against the Trust.

[16] The £6,000 was made up of £3,360 for lunches (including dinners at the day centre) and £2,640 for horse riding and tuck.

Mr and Mrs Taylor's complaints to the Local Government Ombudsman and thereafter the Health Service Ombudsman

39 Mr and Mrs Taylor told the Local Government Ombudsman's Investigator that the compensation so far offered by the Council went nowhere near compensating for the amounts of time and money they had spent in subsidising Frank's care and working on his behalf to secure a better life. They said they had spent much on telephone calls, stationery, attending many meetings and so on; apart from these practical expenses they had sustained significant trauma and suffered from excessive stress as a consequence of the many failings associated with the poor care that Frank received since he was moved in June 2001. The whole family had suffered: Frank's adult brother and sister had shared and suffered from the anxiety and exhaustion experienced in the quest to have him appropriately cared for.

40 Mr and Mrs Taylor said that they had suffered greatly during the period between December 2002 and March 2003 when they looked after Frank at home. As well as the day-to-day care that they gave him, they did not know from one minute to the next how he would behave towards them because he had become so anxious, sometimes literally chasing them around the house. They found his behaviour emotionally draining.

41 Mr and Mrs Taylor said that the accommodation given to Frank when he returned to the Council's care at the end of March 2003 (paragraph 26) was inadequate – a converted storeroom. They considered that Frank received a poor level of care in relation to his needs, and compared to what he later received when he moved out of the area. By way of example, they said that on one occasion in June 2003 when they collected Frank for his weekend visit they found he had a broken arm and was wearing clothing that belonged to another resident.[17] They also felt that Frank had only been placed in alternative appropriate accommodation in September 2003 largely as a result of their own efforts in identifying a home that could provide for all his needs.

42 Later Frank was moved by the Council to an alternative residential home over three hours' drive from Mr and Mrs Taylor's house. As a result, they were unable to see him as often as they would have wished. (The Council has advised that Frank has since moved to a new placement closer to his parents' home at their instigation and with their involvement.)

43 Mr and Mrs Taylor told the Health Service Ombudsman's Investigator that Frank received £17.50 per week in social security benefits, paid to his mother as appointee. He was provided with food, and everything else at the Care Home was supposed to be free. However, they had paid for holidays, clothes, bedding, curtains, extra incontinence pads and other items. They received, and paid, bills for horse riding, lunches at the day centre (he would, otherwise, have had to have taken sandwiches) and tuck. The Trust's offer had covered receipted items (horse riding and lunches). However, Mr and Mrs Taylor felt that they should be reimbursed for their total expenditure, which they estimated at £20,000. They had paid out this money partly from Frank's pocket money and from attendance allowance, which he received only whilst at home, and partly from their own money. The Trust had a budget to cover clothing and other things, yet they still asked Mr and Mrs Taylor to pay for them.

[17] Mr and Mrs Taylor say that there was no case conference or investigation of this incident.

The Council's and the Trust's comments on the agreement

44 The Ombudsmen's Investigators made enquiries of both the Council and the Trust, inspected files and interviewed Officers who had been involved.

45 Whilst both the Council and the Trust have accepted that there had been significant failures in the provision of Frank's care, there is disagreement between them as to the extent to which the agreement they had entered into had the effect of passing overall responsibility for Frank's welfare from the Trust to the Council. On 25 September 2006, in response to the Health Service Ombudsman's enquiries on this point, the Trust's Chief Executive said that from July 2002 the Council had assumed responsibility for providing and funding Frank's care. However, on 27 September 2006, in response to the same query from the Local Government Ombudsman, the Council's Head of Adult Disability Services and Mental Health said that the agreement *'was a provider agreement, not a pooled budget agreement and it clearly did NOT make* [the Council] *responsible'.*

The Council's response to the Local Government Ombudsman's enquiries

46 The Council told the Local Government Ombudsman that, by any objective analysis, the Care Home had been very poorly managed and under-funded before it took over the management. Although the Council had been provided with a copy of the Trust's 'Internal Audit Report' of May 2002, which detailed the prevailing conditions within the small staffed homes it was about to take over, the Council has said that this report was not brought to the attention of senior staff and members who were involved in the negotiations about the agreement.

47 The Council's Strategic Director of Social Services (the Strategic Director) has advised that she felt that much of the complaint investigated and reported upon at Stage 2 of the complaints procedure was essentially about Frank's care as an NHS in-patient and was not, and could not have been, the Council's responsibility as it did not formally provide the services or the care complained about until July 2002. The complaint had been made in September 2002, by which time the Council had taken over managerial responsibility for the 'small health homes' but the Strategic Director considered that it should have been passed to the NHS to investigate under the NHS complaints procedure.

48 The Strategic Director took the view that the Council had been responsible for confusing the complaints process and delaying the investigation of a substantive complaint against the NHS, delay in providing a person-centred plan for Frank and for any shortcomings in the day centre service provision. On 9 July 2003 the Strategic Director wrote to Mr and Mrs Taylor and (on the basis of legal advice) accepted responsibility for (and wished to remedy) the delay in dealing with the complaint, the delay/failure to produce a care plan for Frank, and the failure to implement a suitable vulnerable adult protection plan. The Council offered Mr and Mrs Taylor £4,500 in compensation to reflect these failures, which they declined.

49 The Strategic Director has also said that it is very important to point out that in the spring or early summer of 2003, the Council could

have terminated the agreement, thereby limiting the Council's responsibilities to a short period from September 2002. However, the agreement was not terminated because the Council felt that it was the right thing, both for Frank and other vulnerable residents still living in the small staffed homes, to continue with the agreement. The Council therefore undertook to provide a care plan for Frank, to find alternative residential accommodation and to continue to work with the NHS to ensure that the 'small health homes' were 'reprovided' so that all of the residents could live in decent conditions with suitable and appropriate levels of care.

50 The Council has made the point that at the time the agreement was signed, neither Senior Officers nor Members of the Council had any knowledge of the condition of the homes; otherwise the agreement would not have been entered into – at least, not without modification. Frank now lived in a residential setting which was much more suitable, having had his needs properly assessed and a care plan drawn up and implemented. The Trust had not agreed to the placement and has refused to contribute to its cost.

51 In September 2004 the Council advised the Local Government Ombudsman that remedial action had included:

'information leaflets issued by pharmacists about medication prescribed for residents is copied for their carers and discussed with them if appropriate and staff have been encouraged to challenge the prescriber if they felt medication was being used inappropriately; staff have been trained in the administration of drugs and each home now has a copy of the British National Formulary;

'the Council has negotiated a revised agreement for the operation and reprovision of all small staffed health homes and the financial aspects are nearing completion. This will enable the delivery of reprovision;

'all residents have detailed care plans; new staff are enrolled in a workshop entitled "Awareness of protection of vulnerable adults";

'the homes have current working policies on night supervision and risk assessment and training remains a continuing priority;

'the discussion on the investigation report took place in July 2003 and communication books are now being used where appropriate;

'a person-centred plan was developed for Frank and is now being used at his new placement;

'Care Managers have been given training in person-centred planning and the Council has taken various steps to ensure that the philosophy underlying "Valuing People" is incorporated into managers' day-to-day work;

'Frank's person-centred plan incorporates a monitoring timetable;

'the Council has made an offer of £4,500 to compensate Mr and Mrs Taylor for money spent on Frank's care; for the injustice sustained by both Frank and his parents and for Mr and Mrs Taylor's time and trouble;

'a new placement was found for Frank at a residential home in Norfolk at a cost to the Council of about £114,000 per annum. Frank moved there on 5 September 2003;

'an apology has been made to Mr and Mrs Taylor and the complaints procedure clarified;

'the Operational Work Plan [referred to in paragraph 31 above] *was a result of the recommendation on this issue.'*

52 An advocacy service was contacted but there had been delays in obtaining a suitable advocate for Frank because of the long waiting-list[18]. A named Care Manager was in regular contact with the new home. Frank was on a waiting-list for a local community psychologist and holidays had been arranged for him in September 2004 and May 2005.

53 The Council told the Local Government Ombudsman that it wished to emphasise that the report in April 2002 into small staffed homes had pre-dated the agreement and at that time the managerial responsibility was still with the Trust. However, the Council accepted that the report raised very serious concerns and regretted that it had not been formally afforded as much attention within the Council as it had clearly warranted. The complaint by Mr and Mrs Taylor clearly showed that at the time the Council became aware of these issues, serious problems remained and it was regrettable that it required the complaint to provide the impetus for further action. The Council has engaged in a continuing dialogue with the responsible Primary Care Trust on some of the very complex and difficult funding and operational issues that remain to be satisfactorily resolved.

The Trust's formal response to the Health Service Ombudsman's enquiries

54 In its formal response to the Health Service Ombudsman's enquiries the Trust accepted that there had been a lack of co-ordination in Frank's care, that there was a lack of communication between the teams involved in his care and that important observations about him were not passed on to the team responsible for taking action. Frank did not have adequate support at night, when it was inappropriate for staff to lock their doors, and the cleanliness and general environment at the Care Home had been neglected. The Chief Executive concluded:

'... there were failings in procedures as well as a general shortage of resources, which led to an unsatisfactory level of care for Frank. We would like to repeat the apologies that have been made to date to Mr and Mrs Taylor and also to Frank for the failings in his care and for the distress this has caused.'

55 She went on to outline the improvements that the Trust and the Council had made to all the small staffed homes in the area as a direct result of the complaint and said that the Trust and Council *'now work much more closely together'* and agreements about funding had been reached which had enabled small staffed homes to be significantly improved.

56 The Trust, however, did not agree with Ms B's finding that Frank had not received adequate personal care. Having investigated the matter itself, the Trust said that there was evidence that Frank had received personal care, but could not say whether that was of a standard that Mr and Mrs Taylor would have wished.

[18] Mr and Mrs Taylor have said that it was their efforts that secured this facility – not the Council's.

57 With regard to medication, the Trust's Chief Executive said:

> *'We do not agree that there was excessive or inappropriate use of either of the two drugs (paroxetine and haloperidol) prescribed to Frank. The dose prescribed ... was well within the limits recommended in the British National Formulary.*
>
> *'We do, however, agree with the concerns expressed by the clinical adviser to the Convener in respect of the monitoring of haloperidol as well as Frank's overall treatment plan. In addition we recognise that the delay that occurred in the reduction of Frank's haloperidol prescription following* [a locum consultant psychiatrist's] *telephone conversation with Mr Taylor was unacceptable.*[19]
>
> *'Staff now receive training on the administration of medication including information on the side-effects of medication* [and] *the medication policy has been reviewed, rewritten and training provided. Pharmacists issue information leaflets with the medication they dispense and staff use these to improve their knowledge about the effect of that medication.'*

58 With regard to the monies that Mr and Mrs Taylor had paid out, the Trust's Chief Executive advised the Health Service Ombudsman:

> *'As you are aware, this matter is being handled by the NHS Litigation Authority. At your request, the Trust's Head of Complaints has contacted the NHSLA to ask if a reasonable final offer may be made to Mr and Mrs Taylor.*
>
> *'I would like to end this letter with a full apology to Mr and Mrs Taylor and to Frank for their experience of the service provided by this Trust during Frank's stay at* [the Care Home]. *I fully recognise that this has been a difficult and distressing time for them.'*

59 On 14 June 2006 the Trust advised the Health Service Ombudsman that the NHSLA had given approval for it to increase its offer to Mr and Mrs Taylor to £10,000.

Complaints to the Health Service Ombudsman about medication and recorded diagnoses

60 Mr and Mrs Taylor raised with the Health Service Ombudsman their concerns about Frank's medication, in particular that the combined prescribing and administration of diazepam (a drug to treat anxiety) and haloperidol (a drug to treat mania), with other drugs, had been inappropriate. They told the Health Service Ombudsman's Investigator that they wanted the Ombudsman to consider the prescribing as a whole, and determine whether there was bad practice. They said that Frank's consultant had often prescribed sedation over the telephone without having seen him. Of particular concern, they felt that diazepam was inappropriate for Frank, explaining that when he stayed with them for three months he needed to take only haloperidol and citalopram (a drug for depressive illness or panic disorders). Frank's jaw tended to dislocate, and this had become

[19] During local resolution of this matter the locum consultant psychiatrist accepted that he had failed to make a change to Frank's clinical records to reduce the amount of haloperidol even though he had agreed with Mr Taylor over the telephone that he would do this.

worse after he started taking haloperidol and diazepam. They believed that the drug regime had made Frank *'fat and drowsy'* and caused him to have difficulties getting up and about.

61 Mr and Mrs Taylor also raised a specific concern with the Health Service Ombudsman, which had not been dealt with by either the Council or the Trust as part of their responses about the conditions within the Care Home and the level of care Frank received. Having seen copies of Frank's records, Mr and Mrs Taylor were concerned that he has been *'labelled'* as having bipolar affective disorder and an autistic spectrum disorder. They believed that these diagnoses had only been added to Frank's records when he was transferred to his current home and had been *'invented'* to cover his distress and reaction to the harm and injustice that he suffered at the Care Home. The Health Service Ombudsman decided that it was appropriate to consider this more recent complaint as part of the overall investigation into the standard of care provided for Frank.

Frank's clinical records

62 On 27 May 2002 a locum consultant psychiatrist (Dr A) diagnosed that Frank was depressed and started him on a trial of paroxetine, to be reviewed after eight weeks. Frank's behaviour changed and when he was seen again on 9 July 2002 Dr A recorded that Frank had *'experienced a manic switch from paroxetine. Giggly, disinhibited sexually. Increased energy, irritable. Impression BAD* [bipolar affective disorder]*'*. A letter dated 29 May 2002, written by Dr A to Frank's GP, includes *'autistic disorder'* under *'diagnosis'*, and notes that it was difficult to assess Frank's mood because of his severe autism. A letter dated 23 December 2002 from another consultant (Dr B) to a benefits advice project states that Frank *'has some of the features of autistic spectrum disorder'*.
A computer print-out from Frank's GP practice (which covers prescriptions issued in March 2003) includes *'Significant Medical History ... 29/09/2002 Bipolar affective disorder'*. An entry by Dr B in Frank's medical records (dated 9 April 2003) states *'it is mentioned in the past records that* [Frank] *has Autistic tendencies,* [with] *which I personally disagree. More recently it was mentioned that he suffers from Bipolar affective disorder. There is neither a family history nor the clinical picture to substantiate this'*.

63 Notes of an emergency meeting held on 9 May 2003 to discuss Frank's behavioural problems shortly before that date say *'*[it was] *... suggested Frank might have some autistic tendencies. Although this was not diagnosed, it may be helpful to approach his daily activities ... from a structured approach ... '*.

64 A Discharge Summary Report, dated 15 March 2004, and signed by Dr C, a locum consultant psychiatrist, was sent to Frank's new consultant following Frank's move to a home in another area. This lists Frank's diagnoses as *'severe mental retardation with significant behaviour disorder; autistic spectrum disorder and bipolar affective disorder'*.

Comments of the Health Service Ombudsman's Clinical Adviser

65 One of the Health Service Ombudsman's clinical advisers (the Clinical Adviser – an experienced consultant psychiatrist) has examined the records provided, some going as far back as 1981, and has provided the following comments:

' ... it is accepted that Frank Taylor has severe learning disability. This means that there is a developmental abnormality of his brain function so that his abilities are impaired in all sorts of ways. It sometimes happens that some functions are relatively spared, or some are relatively more severely affected: we do not know whether this is so in Frank's case. The cause of his condition is not known.

'People with learning disability have a higher prevalence of other mental disorders than the general population. Diagnosis is progressively more difficult as the severity of disability increases, not least because of difficulty in communicating, and when speech is absent or very limited more emphasis has to be placed on observation of expression, behaviour and so forth. This is a specialised task. In Frank's case, two additional diagnoses have been made: autism and bipolar affective disorder.

'The term autism began life as a term for a symptom or disposition in which a patient to some extent is isolated in himself, and his relationships with others are correspondingly impaired. Then in 1943 a syndrome of early childhood autism was identified by Kanner. This concept has achieved widespread recognition and may be defined, to paraphrase the International Classification of Disease, as a pervasive developmental disorder with abnormal or impaired development that is manifest before the age of three years with characteristic types of abnormal functioning in various special interaction, communication, and restricted repetitive behaviour. Early childhood autism can occur in association with any level of IQ, but there is a preponderance of patients with learning disability.

'Currently, the core syndrome of early childhood autism is placed with other disorders, in what is sometimes called the autistic spectrum. This includes Asperger's Syndrome, in which autistic traits may be very mild, and have no definite boundary with normal variation. From the records supplied, I can find no rationale for the diagnosis in Frank's case. In the case of people who, like Frank, are severely disabled, relationships obviously have a different quality from those of people with normal intelligence, and communication is difficult; if repetitive, stereotyped behaviour is prominent, it may be reasonable to infer a diagnosis of autism. However, this does not necessarily have very great practical implications for management. There is no specific treatment for autism and the sorts of principles that have evolved in psychological management, such as consistency, and paying attention to whether or not a patient tolerates close contact or environmental changes, are principles that would be established by behavioural analysis of any case of severe learning disability in which sophisticated psychological management was invoked.

'Bipolar affective disorder, formerly called manic depressive psychosis, is a well-established clinical syndrome in which there are episodes of depression and episodes of mania (elation and over activity), with periods of normal mood in between. The illness may take an infinite

variety of patterns, from very rare episodes of one or other, with long periods of normality, to almost continuous episodes of either. It can occur in people of very low IQ, and manifests itself mainly as changes of behaviour. In Frank's case, a possible depression was diagnosed [in May 2002] *and treated with a standard antidepressant: his mood then switched suddenly to mild mania. He had not previously been noted to have any manic spells, and it is quite possible that this brief episode was a side effect of the antidepressant drug. Only time will tell whether he goes on to have more characteristic episodes of this illness.'*

66 The Clinical Adviser also commented, after examining the records, that the medication prescribed to Frank seemed to have been appropriate. He has explained that it had not been inappropriate to prescribe paroxetine when Frank appeared depressed, nor to prescribe haloperidol and diazepam as sedatives. Mr and Mrs Taylor have expressed concern that paroxetine and haloperidol were prescribed together. However, the Clinical Adviser has confirmed that these medications may be given at the same time. Mr and Mrs Taylor also said that the medication caused Frank to become drowsy and put on weight. The adviser has explained that these are unfortunate side-effects of antipsychotic medication, and are not unusual. That said, in common with the clinical advice to the Convener, the Clinical Adviser was concerned to note that Frank had been given a relatively high dose of haloperidol but its effects had not been properly monitored. He commented that the dose of diazepam was also high, though not unusual, and had similarly required monitoring. However, he noted that the Trust had accepted this and had highlighted improvements made to the provision of clinical care at the Care Home, including training in the administration of medication and better use of observation records for improved monitoring of residents. The Clinical Adviser was satisfied that the actions that had been taken should prevent a recurrence of the shortcomings identified.

Health Service Ombudsman's findings on the complaints about medication and recorded diagnoses

67 Mr and Mrs Taylor complained that Frank's medical records contained diagnoses of autistic spectrum disorder and bipolar affective disorder, which they believe were *'invented'* and added when Frank was transferred to a new care regime. There are references to a diagnosis of autistic disorder in Frank's notes from May 2002 and references to possible bipolar affective disorder from July 2002 – the latter following an episode of mania attributed to the use of paroxetine. (These entries appear to have been made some time before Frank's transfer – not added at the time, as Mr and Mrs Taylor believe.)

68 The Clinical Adviser has said that he can find no rationale for a diagnosis of autistic spectrum disorder in Frank's records. It seems that having such a diagnosis recorded would not have caused Frank harm as there is no specific treatment for autism and the principles involved in the psychological management of the condition are apparently similar to those used more generally. Nevertheless, in relation to autism Frank's records contain a diagnosis that appears to be without firm basis.

69 Turning to the diagnosis of bipolar affective disorder, the Clinical Adviser has explained that people with learning disability (such as Frank) have a higher prevalence of mental disorders than the general population and diagnosis can be particularly difficult due to communication problems. In Frank's case, a diagnosis of bipolar affective disorder was noted after he had displayed mild mania following treatment for depression. The Clinical Adviser has commented that the mania might have been a side-effect of antidepressant medication, and that only time will tell whether a diagnosis of bipolar affective disorder is confirmed. Since the events complained of, when the diagnosis of bipolar affective disorder was postulated by Dr A as an *'impression'*, Frank has moved to live elsewhere. His current doctors will no doubt form their own view as to any diagnosis – and thus may eventually confirm, or refute, this impression. Given that the entry in Frank's record was of an *'impression'*, rather than a firm diagnosis, it is difficult to see it as part of an invention aimed at casting Frank in a very bad light and there is no reason to believe that the records are not contemporaneous. On that point, in particular, Mr and Mrs Taylor might be reassured.

70 In light of their concerns about the records, it is open to Mr and Mrs Taylor to ask the Trust to make arrangements with the current holder of Frank's records to place a note therein to reflect the fact that while Frank was under the care of Trust staff the diagnosis of autistic spectrum disorder had not been firmly established and the diagnosis of bipolar affective disorder was provisional and made in the absence of other confirmation. Although the Health Service Ombudsman has concluded that the records on this point do not seem entirely accurate, which in itself is a serious shortcoming, sufficient to amount to maladministration, she nevertheless concludes, in the light of the clinical advice she has been given, that no significant injustice has resulted. Therefore, although she finds that there was maladministration in respect of the recording (particularly in respect of references to autism) she does not uphold this aspect of Mr and Mrs Taylor's complaint.

71 Turning to Mr and Mrs Taylor's concerns over medication, the Health Service Ombudsman has noted her Clinical Adviser's comments: that the prescriptions were not in themselves inappropriate. She has therefore concluded that prescribing those medications does not in itself amount to a failure in service on the part of the Trust, or its doctors. However, she has noted also that both the Trust's Convener's clinical adviser, at an earlier stage in the handling of the complaint, and her own Clinical Adviser were of the view that monitoring of the medication should have been better, and therefore needs to be considered together with the more general complaints about a lack of care which are discussed below.

Local Government Ombudsman's and Health Service Ombudsman's findings on the complaint against the Council and the Trust

72 Frank has severe learning disabilities and needs constant supervision in order to ensure that his complex needs are met. It is clear, as the previous investigation into Mr and Mrs Taylor's complaints have noted, that vulnerable adults like Frank should have their needs regularly assessed and individual care plans generated as a means of safeguarding their welfare and providing them with a good quality of life. Frank and his parents had a right to expect that the Care Home would provide him with appropriate care in an environment conducive to his

development. Sadly, we have found that that did not happen. That is maladministration which in this case has clearly caused both Frank and his family injustice as documented in the report. In addition, we find that the way in which Mr and Mrs Taylor's concerns about Frank's wellbeing were dealt with by both the Council and the Trust also amounts to maladministration, which has undoubtedly caused them a great deal of additional frustration in their attempts to achieve redress.

73 Mr and Mrs Taylor's complaints were considered under the Council's complaints procedure initially. The Council's investigation identified many failings in the service provided to Frank, but made no attempt to put those findings in the context of the legal framework that governed his care or to identify which of the statutory local bodies should investigate specific aspects of the complaint. The whole process took nine months when it should have taken no more than six.

74 In spite of the arrangements set down in the agreement for the handling of complaints (paragraph 15), Mr and Mrs Taylor's concerns were not dealt with either in a timely or appropriate way in the first instance. Instead, it seems likely to us that Mr and Mrs Taylor's concerns must have been compounded when Ms A told them in December 2002 about sexual abuse in the Care Home, sexually deviant behaviour by a resident and that she had made some of their concerns known to Care Home staff – which caused them to fear retaliation against Frank if he returned. This occurred at a time when there was no end to the complaints process in sight.

75 Ms B's report upheld Mr and Mrs Taylor's complaints in their entirety. The Council accepted the report and its recommendations, although it has pointed out that if it had been clearer at that point what it was, and was not, responsible for the complaint might have been resolved earlier. The Trust disputed some of Ms B's findings, commenting that she was not qualified to comment on clinical matters. It therefore decided to conduct its own investigation.

76 In the light of that investigation, the Trust did not accept that Frank's medication had been inappropriate, as Ms B had said. However, it did find that the medication had not been monitored properly. On this aspect of the complaint, the Health Service Ombudsman (paragraph 71) has not identified a service failure but, in common with the Trust, has noted that monitoring of the medication should have been better. She has said that that should be taken into account with the other aspects of Mr and Mrs Taylor's complaints about the provision of care to Frank. She has noted that her Clinical Adviser has commented that action had since been taken by the Trust to address these matters although, of course, that does not provide a personal remedy for Frank or his parents.

77 The Trust said that there was evidence that Frank had received some personal care; although it acknowledged that this may not have been of the standard that Mr and Mrs Taylor expected. The Trust accepted the remainder of Ms B's report.

78 Although there are a few matters that the Trust has disputed, it is clear to us that, when considered in the round, the level of care provided to Frank was unacceptable. In the absence of a proper assessment of his needs, and thereafter a formal care plan, there was

little chance of ensuring that his physical and emotional wellbeing was protected. There was no apparent understanding of, or impetus to meet, the higher level of care that he required. Moreover, the surroundings in which the care was provided, seem to have been far from ideal, as highlighted by the incidents which were reported by Mr and Mrs Taylor, and by others. Due to Frank's inability to express clearly in words his concerns and feelings, it is difficult to say how much these events have impacted upon him. However, there can be little doubt that it was as a direct consequence of both the Trust's and the Council's failure to allay Mr and Mrs Taylor's legitimate concerns about their son's welfare that they felt they had little choice but to care for Frank at home from December 2002 to March 2003. This must have been a very difficult decision to take and, given Frank's care needs, both he and his parents must have found this a trying time.

79 In considering this complaint we were also extremely concerned to note that on occasion staff at the Care Home – who were there to protect and care for the residents – were in the habit of locking their doors at night and were therefore not accessible should the vulnerable people in their charge have needed them. Mr and Mrs Taylor were concerned that, because of this, Frank (who had difficulty in communicating) would have been unable to summon assistance if his jaw had dislocated. Thankfully, that does not appear to have happened; there is no evidence that Frank suffered directly as a result of staff locking their doors, but Mr and Mrs Taylor's concerns are entirely understandable. Like all those who have considered this matter, we find the situation highly unsatisfactory.

80 The agreement brought together responsibilities for the personal welfare and wellbeing of a great many people who depended on these services. Given the financial and human costs involved in getting things wrong, we would have expected to have seen a far greater level of scrutiny on both sides prior to entering into the agreement than was evident here. The Council said that when it did become aware of the situation it could have cancelled the agreement but elected not to do so in the best interests of the residents. For its part the Trust was aware of the prevailing conditions within the homes prior to July 2002 and so cannot expect to absolve itself of responsibility as a result of entering into the agreement with the Council.

81 In terms of Frank's human rights it would be for the courts to determine whether there has been a breach of the Human Rights Act 1998 and if so to make binding declarations and decisions. We have considered whether relevant issues were engaged in Frank's case and whether they were properly taken into account in a timely way by the Council and the Trust.

82 The greater a person's disability or communication difficulties, the greater the need for proper consideration to ensure the protection of basic rights such as human dignity. We have concluded that Article 3 (which includes inhuman or degrading treatment), Article 8 (which includes right to respect for private and family life and home) and Article 14 (prohibition of discrimination) were engaged in Frank's case, and that the Council and the Trust both neglected to give those issues proper or timely consideration. Both bodies have told us that they were aware of their responsibilities under the Human Rights Act, and they may well have policies

and practices to protect the rights of service users and their families, and may have considered human rights factors as an intrinsic part of their decision-making processes. However, this intrinsic (as opposed to specific and conscious) consideration meant that not all the relevant issues were properly taken into account in Frank's case (nor, evidently, in the case of other residents in the home). This failure was so significant as also to amount to maladministration and contributed to the injustice suffered by both Frank and his parents. A proper consideration of human rights issues at any point would have led to improvements in Frank's and his parents' situation.

83 The Trust and the Council are not able to agree about their relative responsibilities in this case. We acknowledge that the Trust was wholly responsible for Frank's care up to the signing of the agreement, but from that point on, although the managerial control of the Care Home passed to the Council, there remains dispute over funding responsibility. What is clear is that, irrespective of the extent of the Council's knowledge about prior conditions in the Care Home, Frank's care needs were not assessed as they should have been at any point during his time there, and that Mr and Mrs Taylor's concerns about his personal care and medication were not adequately addressed which – given the deterioration in Frank's mental and physical wellbeing – left them feeling that they had no choice but to attempt to provide care for his complex needs at home. We believe that the Trust must accept full responsibility for the conditions within the Care Home prior to the agreement coming into force in July 2002. The Trust was maladministrative in allowing the Care Home to deteriorate to the condition that it was in when the transfer of management took place. Thereafter the Council – having entered into the agreement – must assume the overall responsibility for the failures in the provision of the service after it took over managerial control. The Council's failure to properly apprise itself of those conditions when agreeing to take over responsibility for managing and delivering appropriate care to its residents, also amounts to maladministration.

84 We find that during his time in the Care Home Frank's care needs were never properly assessed and the level of care he received was below that which he and his parents were entitled to expect. In addition, we find that Mr and Mrs Taylor were wrongly charged for items which should have been paid for from Frank's funding. We also find that, as a result of the inability of both the Council and the Trust to respond appropriately to their concerns, Frank's parents were caused a great deal of anxiety and distress in attempting to care for him for a period of three months at home without any external support, as they did not feel that he could return to the Care Home about which they were so concerned.

Remedy

85 The Council and the Trust have accepted that Frank's care was not of the standard that he and his parents had a right to expect and have outlined the action that has been taken to address the shortcomings identified in the reports that they have commissioned. We have considered this carefully and are satisfied that significant steps have been taken to improve the care provided to patients such as Frank. However, Frank is no longer resident in the Care Home and his parents have pointed out that those changes are of no benefit to him.

86 In establishing an appropriate remedy in this case we have considered a number of factors. It is clear that Frank and his parents have sustained injustice as a consequence of the maladministration identified in this report. Frank did not receive the care that he and his parents had a right to expect, and the lack of adequate care planning meant that he was denied the opportunity to develop to his full potential. Conditions in the Care Home were poor, it seems that staff did not always pay due care and attention to Frank's physical and personal needs; medication was not monitored adequately. The Trust has accepted this.

87 It is evident that Frank's parents suffered acute anxiety and distress worrying about him whilst he was resident in the Care Home and physically looking after him themselves from December 2002 to March 2003. While Frank was living at home Mr and Mrs Taylor received no external help or support. It cannot have been easy for them having Frank home at this time, given his depression and panic attacks, and we have no doubt that this put a strain on the whole family. Mr and Mrs Taylor only returned their son to the Council's care after he had suffered a panic attack on the way home from the day centre. Given that their concerns about Frank's welfare within the Care Home had yet to be fully addressed, it must have been very difficult for Mr and Mrs Taylor to return Frank to the Council's care.

88 Mr and Mrs Taylor say that they have also paid for items over a sustained period of time that should have been covered by the Trust from Frank's benefits. In October 2003 the Trust's Interim Chief Executive agreed in principle that the Trust should have been responsible for the majority of items listed in Ms B's report. However, when the Trust subsequently made an offer, that did not cover everything, being limited to those items for which Mr and Mrs Taylor had receipts.

89 To date the Council has offered the sum of £4,500 to Mr and Mrs Taylor by way of redress, and the Trust has advised that it is prepared to increase its initial offer of £6,000 to around £10,000 to cover the disbursements that Frank's parents have wrongly incurred. We have given careful thought to the injustices suffered by Frank and his parents and consider them to be substantial. Having done so, we do not believe that the offers of compensation made so far by the Council and the Trust provide sufficient remedy.

90 As noted above, there is some disagreement between the Council and the Trust as to their relative responsibilities (especially over funding) for Frank's care, and we would like to reiterate that we believe they must share equal responsibility. A lack of proper governance arrangements, that has resulted in neither the Trust nor the Council being able to agree where overall responsibility for Frank lay at a crucial point, is a matter for them. Although we

recognise that the Council cannot be held responsible for the conditions within the Care Home before it assumed overall managerial responsibility, it has accepted that it should have known about them. The disagreements do not change our conclusions – each is accountable as providers and our view is that they should share the effect of the remedy proposal in terms of compensation.

91 We recommend that a payment of £32,000 is made. In determining this sum we considered the injustices identified:

- The expenses that Mr and Mrs Taylor paid out unnecessarily while Frank was resident in the Care Home (although they estimate this to be £20,000 in total, it is not now possible to substantiate that this total is comprised exclusively of costs that should have been met by the Care Home. We concluded that a more reasonable sum, in respect of the expenses unnecessarily incurred directly by Mr and Mrs Taylor, is just in excess of £10,000).

- The acute anxiety and distress Frank and his parents must have experienced as a result of the poor standards of care he received whilst he was resident in the Care Home.

- Mr and Mrs Taylor's efforts in physically looking after him without any external help or support from December 2002 to March 2003 during which time the Care Home was being run and managed by the Council, and the costs that they incurred during this time.

- The distress that the whole episode has caused to Frank, Mr and Mrs Taylor and Frank's siblings which the Council accepts was compounded by its failure to deal with their initial complaint of September 2002 in an appropriate or timely fashion (paragraph 30).

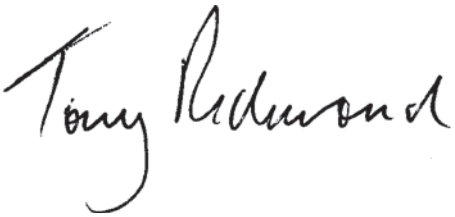
We therefore recommend that the Trust and the Council each make a payment of £16,000. We leave it to Mr and Mrs Taylor to decide how best to use this payment.

92 Although the Council has questioned why it should be asked to pay £16,000, given that it was not responsible for most of the expenses unnecessarily incurred by Mr and Mrs Taylor, it must take responsibility for the three-month period when Frank was being accommodated at home without support and the costs Mr and Mrs Taylor incurred during this time, as well as the distress and anxiety caused to them. It must also recognise that its failure to deal with their complaints in accordance with the statutory timescales in place at that time further frustrated their attempts to ensure Frank was re-housed in a more appropriate care setting as soon as was possible following their initial request that this was done in September 2002.

Conclusion

93 The Health Service Ombudsman concluded that the prescriptions of medications in combination had not been inappropriate, and that prescribing those medications did not amount to a failure in the service provided by the Trust or its doctors. She found that there was maladministration in the recording of diagnoses in Frank's medical records. She did not, however, find that the maladministration resulted in significant unremedied injustice and did not uphold this aspect of Mr and Mrs Taylor's complaint.

94 However, in terms of the more general complaints about the lack of care provided to Frank we have found that maladministration by both the Council and the Trust resulted in unremedied injustice to Frank and his parents. We therefore uphold the complaints by Mr and Mrs Taylor against both the Council and the Trust.



Ann Abraham
Parliamentary and Health Service Ombudsman

Tony Redmond
Local Government Ombudsman

March 2008

Printed in the UK by The Stationery Office Limited
on behalf of the Controller of Her Majesty's Stationery Office
ID5780965 03/08

Printed on Paper containing 75% recycled fibre content minimum.

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London SW1P 4QP

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ISBN 978-0-10-295341-1
9 780102 953411