Parliamentary
and Health Service
Ombudsman

A report by the Health Service Ombudsman and the Local Government Ombudsman about the care and support provided to a vulnerable person living independently in the community

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Contents

Foreword ... 5

Summary ... 7

Section 1: Introduction ... 9

The complaint ... 9

- Matters investigated ... 9
- Summary of our decision ... 9
- The Health Service Ombudsman's remit ... 10
- The Local Government Ombudsman's remit ... 10
- Powers to investigate and report jointly ... 10

Section 2: The basis for our determination of the complaint ... 11

The general standards ... 11

The specific standards ... 12

- Legislation ... 12
- National guidance ... 12
- Professional standards ... 13
- Human rights considerations ... 14

Section 3: The investigation ... 15

Key events ... 15

- Background ... 15
- Specialist advice ... 20
- Our joint findings in relation to the complaint about both bodies which, through the community mental health team, had joint responsibility for managing Mr B's care plans ... 25
- Injustice ... 27

Conclusions ... 29

Recommendations ... 29

Section 4: Final remarks ... 31

Annex ... 33

The evidence from interviews ... 33

- The community psychiatric nurse (CPN) ... 33
- The support worker ... 35
- The community mental health team manager ... 36
- The personal care services manager ... 38
- The community mental health services manager ... 39

Foreword

I am laying before Parliament, under section 14(4) of the *Health Service Commissioners Act 1993* (as amended), this report of a joint investigation into a complaint made to the Local Government Ombudsman for England and to me as Health Service Ombudsman for England.

The complaint is about 5 Boroughs Partnership NHS Trust and St Helens Metropolitan Borough Council. The complaint was made by Ms A about the care provided to her cousin, the late Mr B.

My reason for laying this report before Parliament is to allow the joint investigation report to be in the public domain.

Ann Abraham
Parliamentary and Health Service Ombudsman
July 2011

Summary

The Health Service Ombudsman and the Local Government Ombudsman carried out a joint investigation into serious complaints about the support provided to a vulnerable person, living independently in the community, by 5 Boroughs Partnership NHS Trust (the Trust) and St Helen's Metropolitan Borough Council (the Council).

Mr B had had a long history of involvement with mental health services, which had included compulsory detention in hospital and a suicide attempt. By 2006, at the time of the events which we have investigated, he had been living independently in his own home for more than ten years, receiving support from Trust and Council staff. He received regular visits from cleaners and from a support worker who helped with his shopping and budgeting and household chores. He had a care co-ordinator: a community psychiatric nurse, who usually visited him fortnightly to administer medication and to monitor his mental health.

Ms A, his cousin, complained to us that, after she had moved back to the area and had begun to visit Mr B again, she found him to be very unwell and living in a filthy and unsanitary state. She had made efforts to alert the Trust and the Council to her concerns but had not been satisfied with their responses. Finally, when Mr B was admitted to hospital suffering from malnutrition and dehydration and a number of other symptoms, he was investigated for cancer, and was later diagnosed with myeloma – a form of bone marrow cancer – which was to lead to his death in June 2010.

The complaints we investigated were: that in March 2008 Mr B's consultant psychiatrist had failed to respond appropriately to his poor physical state and had instead prescribed inappropriate drugs for depression; that no one had supported Mr B to claim the welfare benefits to which he was entitled; and, that care plans were not implemented and that no one had responded appropriately to developing signs of risk to Mr B's physical and mental health. Ms A complained especially that, as a consequence of these failures, Mr B had lived in squalor and pain; and, that by the time it was recognised that he needed to be admitted to hospital he was so ill and weak that he could not receive the usual treatment for myeloma and so his life expectancy had been considerably reduced. Having taken clinical advice, we did not uphold the first two of Ms A's complaints: about the psychiatrist or the support provided to claim benefits. However, we found that the Trust and the Council had failed in their joint responsibility to manage and implement Mr B's care plans and to take adequate account of developing signs that he was at risk. We considered that there had been insufficient contact with Mr B over a period – his living conditions deteriorated and his personal health was neglected so that, when he began to experience critical ill health in February 2008, staff were not in a position to recognise the urgency of his situation. Thus, Mr B's physical condition deteriorated quickly to an unacceptable state. Although we could not conclude definitely that a different outcome would have resulted for Mr B, in terms of the diagnosis and treatment of his myeloma, we did find that the failure to implement his care plans and to manage risk appropriately played some part in his rapid deterioration.

Mr B died whilst our investigation was in progress, so we were unable to make any recommendations for remedy which would have been of direct benefit to him personally. However, we recognised the significant distress and emotional upset which the Trust's and the Council's service failures had caused to Mr B's family, especially Ms A, and our recommendations therefore include not only an apology to her from both bodies, but also the

payment of £2,000 financial redress to her, and a further £1,500 in respect of the firm of solicitors which had assisted her in making her complaint. The Trust and Council have accepted our recommendations.

Section 1: Introduction

1 This is the report of our joint investigation into Ms A's complaint made on behalf of her cousin Mr B, about the 5 Boroughs Partnership NHS Foundation Trust and St Helens Metropolitan Borough Council. Mr B, who has since died, gave permission for Ms A to complain on his behalf. This report contains our findings, conclusions and recommendations with regard to Ms A's areas of concern.

The complaint

2 Mr B had had a diagnosis of schizophrenia for some time. In 2007 he had been living in the community, supported via a care plan managed and implemented jointly by the Trust and the Council, through a community mental health team (CMHT), for more than ten years. It appears that these arrangements worked satisfactorily until approximately 2006. In 2007 his cousin, Ms A, moved back to his area. Mr B visited her and his aunt in February 2008 saying that he was unwell. Ms A went to his home to collect clothes for him and found it in a filthy and unsanitary state.

3 Ms A made attempts to alert the Trust and the Council to Mr B's unacceptable living conditions and to his deteriorating mental and physical health but was not satisfied with their responses. On 4 April 2008 Mr B was admitted to Whiston Hospital, suffering from severe malnutrition, dehydration, a severe fungal infection of his toenails, anaemia and impaired kidney function. Malignancy was suspected and he was later diagnosed with myeloma, a form of cancer of the bone marrow. Mr B died in June 2010.

Matters investigated

4 The matters investigated by the Ombudsmen were:

- Complaint about the Trust:
  - in March 2008 a psychiatrist failed to respond appropriately to Mr B's poor physical state; instead he prescribed inappropriate drugs for depression.
- Complaint about the Council:
  - no one supported Mr B to claim the benefits to which he was entitled.
- Complaints about both bodies who, through the CMHT, had joint responsibility for managing Mr B's care plans:
  - care plans were not implemented, and no one responded appropriately to the developing signs of risk to Mr B's physical and mental health.

5 Ms A said that as a consequence of these failures, Mr B had lived in squalor and pain. She says that on his first admission to hospital, he had been so ill that it had not been certain whether he would survive. He had been too weak to receive the normal treatment for myeloma, and so his life expectancy had been considerably reduced.

Summary of our decision

6 We have considered all the available evidence related to Ms A's complaint about the Trust and the Council, including her recollections and

views. We have taken account of the clinical advice we have received and reached a decision.

7 We have not found that the Trust's psychiatrist failed to provide appropriate care to Mr B or that the Council failed to support Mr B in claiming benefits. However, we have found that the Trust and the Council failed in their joint responsibility to manage and implement care plans for Mr B and to take adequate account of the developing signs of risk. This was service failure which contributed to the injustice of unnecessary pain and neglect experienced by Mr B. We uphold the complaint made about both the Trust and the Council.

The Health Service Ombudsman's remit

8 By virtue of the *Health Service Commissioners Act 1993*, the Health Service Ombudsman is empowered to investigate complaints about the NHS in England. In the exercise of her wide discretion she may investigate complaints about NHS bodies such as trusts, family health service providers such as GPs, and independent persons (individuals or bodies) providing a service on behalf of the NHS.

9 In doing so, she considers whether a complainant has suffered injustice or hardship in consequence of a failure in a service provided by the body, a failure by the body to provide a service it was empowered to provide, or maladministration in respect of any other action by or on behalf of the body. If she finds that service failure or maladministration has resulted in an injustice, she will uphold the complaint. If the resulting injustice is unremedied, in line with her Principles for Remedy, she may recommend redress to remedy any injustice she has found.

The Local Government Ombudsman's remit

10 Under the *Local Government Act 1974* Part III, the Local Government Ombudsman has wide discretion to investigate complaints of injustice arising from maladministration by local authorities (councils) and certain other public bodies. She may investigate complaints about most council matters, including social services and the provision of social care.

11 If the Local Government Ombudsman finds that maladministration has resulted in an unremedied injustice, she may recommend redress to remedy any injustice she has found.

Powers to investigate and report jointly

12 *The Regulatory Reform (Collaboration etc. between Ombudsmen) Order 2007* clarified the powers of the Health Service Ombudsman and the Local Government Ombudsman, with the consent of the complainant, to share information, carry out joint investigations and produce joint reports in respect of complaints which fall within the remit of both Ombudsmen.

13 In this case, we agreed to work together because the health and social care issues were so closely linked. A co-ordinated response consisting of a joint investigation leading to the production of a joint conclusion and proposed remedy in one report seemed the most appropriate way forward.

Section 2: The basis for our determination of the complaint

14 In general terms, when determining complaints that injustice or hardship has been sustained in consequence of service failure and/or maladministration, we usually begin by comparing what actually happened with what should have happened.

15 So, in addition to establishing the facts that are relevant to the complaint, we also need to establish a clear understanding of the standards, both of general application and which are specific to the circumstances of the case, which applied at the time the events complained about occurred, and which governed the exercise of the administrative and clinical functions of those bodies and individuals whose actions are the subject of the complaint. We call this establishing the overall standard.

16 The overall standard has two components: the general standard, which is derived from general principles of good administration and, where applicable, of public law; and the specific standards, which are derived from the legal, policy and administrative framework and the professional standards relevant to the events in question.

17 Having established the overall standard we then assess the facts in accordance with the standard. Specifically, we assess whether or not an act or omission on the part of the body or individual complained about constitutes a departure from the applicable standard.

18 If so, we then assess whether, in all the circumstances, that act or omission falls so far short of the applicable standard as to constitute service failure or maladministration.

19 The overall standard we have applied to this investigation is set out below.

The general standards

20 In February 2009 the Health Service Ombudsman republished her *Principles of Good Administration*, *Principles of Good Complaint Handling* and *Principles for Remedy*.[1] These are broad statements of what she considers public bodies should do to deliver good administration and customer service, and how to respond when things go wrong. The same six key Principles apply to each of the three documents. These six Principles are:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right, and
- Seeking continuous improvement.

21 Two of the Principles of Good Administration particularly relevant to this complaint are:

> '*Getting it right*' – public bodies should provide effective services with appropriately trained and competent staff. Where public bodies are subject to statutory duties, published service standards or both, they should plan and prioritise their resources to meet them.
>
> '*Putting things right*' – when mistakes happen, public bodies should acknowledge them, apologise, explain what went wrong and put things right quickly and effectively.

[1] The *Ombudsman's Principles* is available at www.ombudsman.org.uk.

22 In cases where the Health Service Ombudsman identifies maladministration and/or service failure, it does not necessarily follow that she will also find that injustice has been caused as a result.

The specific standards

Legislation

23 The *National Health Service and Community Care Act 1990* clarified that local authorities had a duty to assess the individual community care needs of any person who, in their view, required services, and then to decide what services should be provided. This Act also required health authorities to assist in the assessment of need in cases where the person appeared to require the services of the NHS.

24 The *Mental Capacity Act 2005* provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. It makes it clear who can take decisions, in which situations, and how they should go about this. This Act is underpinned by a set of five key principles:

- Every adult has the right to make his or her own decisions and must be assumed to have capacity to make them unless it is proved otherwise.
- A person must be given all practicable help before anyone treats them as not being able to make their own decisions.
- Just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision.
- Anything done or any decision made on behalf of a person who lacks capacity must be done in their best interests.
- Anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms.

25 The *Mental Capacity Act 2005* sets out a test for assessing whether a person lacks capacity to take a particular decision at a particular time. It also established a new Court of Protection and the Office of the Public Guardian. The Court of Protection may decide whether a person has capacity and appoint a deputy to make decisions on behalf of a person who lacks capacity to do so for themselves. The deputies are supervised by the Office of the Public Guardian.

National guidance

26 In 1999 the Department of Health published *Effective care co-ordination in mental health services: modernising the care programme approach*, which contains specific guidance on the role of the care co-ordinator. This includes:

> *'Effective care co-ordination should facilitate access for individual service users to the full range of community supports they need in order to promote their recovery and integration. It is particularly important to provide assistance with housing, education, employment and leisure and to establish appropriate links with criminal justice agencies and the Benefits Agency.'*

27 The Department of Health also published the *Mental Health Policy Implementation Guide Community Mental Health Teams* in 2002. This document sets out expectations for CMHTs relating to: working with primary care; assessment; team approach; regular review; and interventions. It includes the requirement for:

- regular review of progress and outcomes
- care plans to be formally reviewed and updated
- that there should be a single written record for each service user
- case workers should not take on a caseload of more than 35 to 40 cases
- physical health problems to be identified and discussed with GPs
- families and carers to be involved as much as possible.

Local guidance

28 The Trust and the Council published an interagency policy and procedure relating to the protection of vulnerable adults in St Helens: *Safeguarding Vulnerable Adults Protocol* 2006. This included a section headed '*Intervention threshold*', which stated:

> *'1.3.1 The term "intervention threshold" is used to try and determine at what level of "threshold" the statutory agencies should intervene in the affairs of an adult deemed to be vulnerable and at risk through their own action or the action of others. The decision to intervene should only be taken when the behaviour or risk is felt to be to an unacceptable level. This decision may, therefore, involve advice from other professionals such as doctors, psychologists, line managers and, if necessary, solicitors.*
>
> *'1.3.2 The* [Department of Health's] *guidance "No Secrets" suggests that in determining whether to intervene: "harm should be taken to include not only ill-treatment … but also the impairment of, or an avoidable deterioration in, physical or mental health …"'*

Categories of mistreatment are identified in paragraph 1.3.5 of the guidance. They include '*neglect (of self or by others)*'.

Professional standards

29 The General Medical Council (the GMC – the body responsible for the professional regulation of doctors) publishes *Good Medical Practice*, which contains general guidance on how doctors should approach their work. This represents standards which the GMC expects doctors to meet. It sets out the duties and responsibilities of doctors and describes the principles of good medical practice and the standards of competence, care and conduct expected of doctors in all areas of their work. It states that, amongst other things, good clinical care must include adequately assessing the patient's condition taking account of the history; providing or arranging investigations or treatment where necessary; and referring a patient to another practitioner, when this is in the patient's best interests.

30 The Nursing and Midwifery Council (the NMC – the body responsible for the professional regulation of nurses) publishes *Guidelines for*

records and record keeping, which contains general and specific guidance on the standard of record keeping expected of nurses. The version of the guidelines that was in place at the time of these events was superseded in 2009. On page 8, the guidance stated that records should: '*... be written as soon as possible after an event has occurred, providing current information on the care and condition of the patient or client*'.

31 On page 10, the guidance said:

> '*The approach to record keeping that courts of law adopt tends to be that "If it is not recorded, it has not been done". You must use your professional judgement to decide what is relevant and what should be recorded. This applies particularly to situations where the condition of the patient or client is apparently unchanging and no record has been made of the care delivered.*'

Human rights considerations

32 Public bodies (and some other bodies with public functions) must comply with the *Human Rights Act 1998*. Underpinning human rights law are the key principles of fairness, respect, equality, dignity and autonomy.

33 It is not the role of Ombudsmen to adjudicate on matters of human rights law or to determine whether the law has been breached – those are matters for the courts. The Health Service Ombudsman's Principles of Good Administration do, however, state that the Principle of '*Getting it right*' includes acting in accordance with the law and with regard for the rights of those concerned, and taking reasonable decisions based on all relevant considerations.

34 If it appears to us that someone's human rights are engaged in relation to the events complained about, we will expect the public body, in accordance with the Principles of Good Administration, to have had regard to those rights in the way it has carried out its functions, and to have taken account of those rights as a relevant consideration in its decision making.

Section 3: The investigation

35 Our staff met Ms A on 29 September 2009 to discuss the nature of her concerns, and the way in which we would investigate the complaint, and confirmed our understanding of the complaint in a letter to her dated 5 October, which also confirmed the issues we would investigate.

36 During this investigation we have examined relevant evidence. This includes papers provided by Ms A's solicitors, video footage taken by Ms A of Mr B at home in March 2008, Mr B's medical records and the papers relating to the attempted resolution of the complaint by the Trust and the Council. Since we started our investigation, the Trust has undertaken further work to review the complaint and we have taken account of its review. We have interviewed the Trust's and the Council's staff involved in Mr B's care, and their managers.

37 We obtained specialist advice from three of the Health Service Ombudsman's clinical advisers, a GP (the GP Adviser), a consultant psychiatrist (the Psychiatric Adviser) and a registered mental health nurse (the Nursing Adviser). The Health Service Ombudsman's clinical advisers are specialists in their field, and in their roles as advisers to the Health Service Ombudsman they are independent of any NHS body.

38 In this report we have not referred to all the information examined in the course of the investigation, but we are satisfied that nothing significant to the complaint or our findings has been omitted.

Key events

39 This account of events has been taken largely from the contemporaneous records, with some additional information provided by Ms A.

Background

40 Mr B's past history included admissions to hospital, detention under the *Mental Health Act 1959* and a suicide attempt in 1998. In 2006 he had been receiving community care support while living independently for more than ten years.

41 Mr B's care plan included regular visits from cleaners (provided by the Council's Homecare service) and from a support worker whose role was to assist him with shopping, budgeting, cleaning and cooking. A community psychiatric nurse (CPN), who was Mr B's care co-ordinator, was to visit him fortnightly to administer his medication by injection and monitor his mental health.

42 A risk assessment was drawn up in 2004 and countersigned *'no change'* in 2005, 2006 and 2007. This identified risks to Mr B through attempts at self-harm, deterioration in mental health, neglect of medical needs, difficult personal relationships, social isolation, level of understanding and insight and neglect of dietary needs. The assessment identified triggers for concern which included:

> *'domestic circumstances deteriorating in flat … sleep disturbance … increasing evidence of self neglect … not engaging for visits … not allowing personal care in … dirty kitchen and utensils … unsafe storage of food.'*

The management plan included twice weekly visits by the support worker; encouraging kitchen hygiene and a more varied diet; and informing the CPN of all concerns or failed visits.

43 Over the years, there were often difficulties in gaining access to Mr B to monitor his welfare or to provide care services. On more than one occasion, his flat had become excessively dirty and additional heavy cleaning work was undertaken.

44 In 2004 Mr B was seen to have problems with his toenails. His support worker went with him to the GP and in March 2005 to hospital for an operation. The operation was cancelled. The support worker went with him on a second occasion, but this time it appears that Mr B had not followed the instructions not to drink beforehand and so the operation could not proceed. In October 2005 a new appointment was made but Mr B refused to attend.

45 The CPN encountered similar difficulties when Mr B had problems with his teeth in 2005. The CPN had gone with Mr B to the dentist on one occasion. However, Mr B believed that problems with his teeth arose from the police X-raying them and refused to go again.

46 There is evidence in the record that efforts were made in 2005 to move Mr B into supported accommodation. The possibility of a move was discussed on a number of occasions, but after a long discussion with the CPN and the support worker on 1 August, Mr B refused the move.

Key events from 2006 to 2008

47 During 2006 the support worker regularly visited Mr B. The usual pattern of a visit was that they would go together to the Post Office to collect his benefits. Sometimes they did some shopping but sometimes they just chatted. There were many references in the records of the support worker's visits to Mr B appearing smart, clean and shaven. The number of failed visits by both the support worker and the CPN appears to have increased during the year.

48 In January 2007 the support worker specifically noted that the flat appeared clean and tidy, and that Mr B looked well. In February the support worker noted that Mr B:

> *'had no money due to paying a "big bill". Advised* [Mr B] *to count the money in his money jar. The last time we counted it, it was over £50 in loose change.* [Mr B] *said he would change it into notes.'*

49 On 23 March 2007 a second CPN saw Mr B and recorded: '[Mr B] *was pale and dishevelled his living conditions are very grubby the carpet and suite were badly soiled'*. However, the support worker noted that Mr B was *'very smart'* on 2 April.

50 In May 2007 a cleaner reported: *'rang senior* [Mr B] *had a lot of flies in kitchen all over walls & cupboards. Senior told us to get out, she would get in touch with Environmental Health'*. On the following day it appears that the senior visited Mr B, found the kitchen ceiling full of flies, opened windows, emptied rubbish, cleaned unit tops – the rest of the record is unreadable.

51 In August 2007 the CPN helped Mr B to complete the form applying for a loan for a

new bed, as his old one had collapsed and he had been sleeping on the mattress on the floor or the sofa. (This application was refused in October 2007.)

52 In September 2007 a cleaner reported: '[Mr B] *needs some attention to his toe nails very bad will inform senior'*.

53 In November 2007 a cleaner recorded: *'rang senior* [Mr B] *had a lot of flies in kitchen it was a mess did what we could'*. On 26 November, the support worker noted that Mr B's phone was disconnected:

> '[Mr B] *said that he doesn't want a phone. He cannot afford the phone bill. Advised* [Mr B] *it was an essential item.* [Mr B] *said if there were any problems, he would tell me.'*

54 Mr B visited his aunt and Ms A just before Christmas 2007. Ms A said that they noticed that he appeared to be declining in physical and mental health. He reassured them that he was being looked after.

55 In December 2007 the CPN saw Mr B twice. On 3 December he discussed the possibility of applying again for a loan so that Mr B could buy himself a new bed. He also visited on 24 December, when he checked that Mr B had sufficient and suitable food for the holiday period and that he knew whom to contact if he needed any help. Also in December, the support worker saw Mr B seven times. He usually went with Mr B to the Post Office to collect his benefits, to sort out any bills and do some shopping. However, on these occasions, Mr B refused help. The support worker recorded no concerns: Mr B *'seemed fine'*. However, after a number of failed visits, the Homecare service raised concerns that their team was not meeting Mr B's needs. The Homecare manager arranged to make a joint visit with the CPN on 7 January 2008 in order to discuss how they could better meet his needs.

56 In January 2008 the support worker made five visits to Mr B but only saw him once, on 14 January, when they discussed the fact that Mr B had now been given a loan to buy a new bed. In the same month, the CPN made five visits at which he did not manage to see Mr B, including two attempted joint visits with the Homecare manager. However, he did see Mr B on 9, 24, 25, 28 and 29 January. These visits included reminding Mr B about an appointment with his GP on 28 January, and to go with him to the GP. However, the appointment was cancelled. The CPN and Mr B went out together on 29 January to buy a new bed and bed linen.

57 In February 2008 Mr B's regular CPN was absent from work and other CPNs tried unsuccessfully to visit Mr B on eight occasions between 7 and 11 February. The crisis team were approached to try to make contact with Mr B and ensure that he received his regular injection of medication. The support worker also failed to make contact on 11 and 14 February. It appears that the Homecare cleaners did see Mr B on 7 February, but they were unable to make contact when they attended on 14 February.

58 On or around 15 February 2008 Mr B arrived at his aunt's house, where Ms A was also staying. By Ms A's account, he was extremely dirty and unkempt and had lost a lot of weight. He said that he was unwell and had backache and asked if he could stay for a while. They agreed and contacted the care team so that Mr B could have his regular injection at his aunt's house.

59 Meanwhile, Ms A went to Mr B's flat to collect some clothes for him. She says that the state of the flat was horrifying: there were cockroaches and flies; there was food over a year out of date; uncovered uneaten takeaway food; there were stains on every surface and faeces and urine stains on the carpets and furniture. Ms A said that she spent several days cleaning the flat and threw out more than 30 bags of rubbish. She said that there was a great deal of money in loose change lying about (Mr B did not like using coins) and that there were many toys, including some expensive items.

60 On 18 February 2008 the support worker visited and met Ms A at Mr B's flat. She told him that Mr B was staying with her and the support worker reported this to his manager and to the CMHT manager.

61 Mr B returned to his flat on 19 February 2008 and Ms A agreed that she would visit him daily. When she visited on 22 February, Mr B told her that he had spent the night in hospital following an overdose of medication. (She learnt later that Mr B's telephone was disconnected so that he had not been able to call for an ambulance; he had walked to the police station for help.) She also found that his cooker and washing machine were not working.

62 On 25 February 2008 Ms A met Mr B's support worker again. She said that the support worker told her that he had no right to interfere in the way Mr B was living. She tried to contact the CMHT manager by telephone but he did not return her calls.

63 On 5 March 2008 Mr B had an appointment with his psychiatrist, which Ms A and a CPN also attended. The psychiatrist diagnosed depression and prescribed fluoxetine. He also wrote to Mr B's GP drawing his attention to Mr B's poor physical health.

64 On 11 March 2008 Ms A called the GP and asked her to make a home visit; Mr B had severe back pain. The GP prescribed diclofenac sodium (a strong pain killer). It appears that Mr B never received this prescription; the GP was unwilling to issue it to Mr B because of the risk of overdosing and Ms A did not know that the prescription had been proposed until some time later.

65 Ms A spoke to the CMHT manager on 23 March 2008 and expressed her concerns. She spoke to him again on 26 March. Ms A told us that at that point, Mr B was so weak he was barely able to walk. She had been trying to get him to eat but he struggled to manage more than a few mouthfuls. He had a severe fungal infection in his toenails and pressure marks on his buttocks, back and shoulders.

66 On 2 April 2008 Ms A called the GP to see Mr B at home. The GP recorded: *'weight loss +++ faecal incontinence, cachexic,*[2] *naked on settee vv pale marked deterioration since last visit'*.

67 The GP arranged for Mr B to be admitted to hospital as an emergency. On admission, he was found to be severely malnourished, dehydrated, lethargic and confused, occasionally incontinent of both faeces and urine. He was able to walk without assistance, but needed help to get up. A malignancy was suspected and a diagnosis of myeloma was made a few days later. After spending some time in hospital, Mr B moved to a nursing home. He died in June 2010.

[2] Generally weakened and emaciated.

The progress of the complaint

68 Ms A voiced her concerns to the CMHT manager as described above. Ms A met the Trust's and the Council's staff on 29 April 2008 and asked for a full investigation. She heard nothing further despite follow up letters and so a formal written complaint was made on 17 July.

69 The Trust and the Council carried out an investigation, interviewing the CPN, and the support workers and their managers. The Trust responded on behalf of both bodies on 24 September 2008. They denied any suggestion that there had been fault by either the Council's or the Trust's staff. They said that Mr B was a long standing, voluntary patient with capacity, entitled to reject assistance, which he did.

70 Ms A's solicitors sent a pre-action protocol letter on 30 September 2008, specifically asking for the complaints process to continue. However, both the Trust and the Council withdrew from the complaints process; the matter was referred to the NHS Litigation Authority, which rejected all claims on 31 December.

71 Ms A's solicitors made a complaint jointly to the Local Government Ombudsman and the Health Service Ombudsman dated 19 February 2009, explicitly stating that legal action was not being taken. They asked that due to Mr B's limited life expectancy, and the failure of the bodies so far to conduct full investigations, the complaint be investigated by the Ombudsmen rather than be referred back to the bodies.

Ms A's recollections and views

72 Our staff met Ms A on 29 September 2009. She said that she had recently come to live with her aunt because of her aunt's need for care. Her aunt had previously been involved in reviews and discussions about Mr B's care with a social worker, but this contact had stopped in the last two years – she did not know why. She had only become involved with Mr B since December 2007 when he had visited her aunt.

73 Ms A said that she had been very shocked by Mr B's state when he visited his aunt in February 2008 and asked to stay. She was horrified by the state of his flat – the heating was on full and there was a powerful smell. Everywhere was extremely untidy and dirty.

74 Ms A clarified the main issues she was concerned about. She said that she did not believe that cleaners had attended when they should have done and did not clean when they did attend; they claimed to have attended when they had not. Ms A also expressed concerns that Mr B's carers had not ensured that he had access to a telephone, or to a cooker or washing machine that worked properly. She thought that Mr B had not been given appropriate help to claim benefits or to manage his money sensibly; he was allowed to buy toys rather than food.

75 Overall, Ms A said that there had been care plans which had not been implemented. There were also risk assessments identifying factors that should have given rise to concern and further action. These factors had been present but not identified or acted upon. Consequently, Mr B's physical and mental health had deteriorated to the point when he was admitted to hospital in a severely ill condition.

The Trust's position

76 After our investigation started, the Trust carried out a further review of Ms A's complaint. In a letter to the Health Service Ombudsman dated

9 December 2009, the Chief Executive of the Trust wrote:

> *'In the first instance, I would like to acknowledge that the initial complaint investigation into Ms A's concerns (raised through* [her] *solicitors) was not of an acceptable standard and did not identify any concerns relating to Mr B's deteriorating health.*
>
> *'A subsequent review and investigation of the care provided to Mr B has identified that the Trust did not provide an appropriate or acceptable level of care to him, and I offer my sincere apologies to both Mr B and Ms A for any distress this has caused.'*

77 In relation to Ms A's complaint that psychiatrists had not treated Mr B appropriately in consultations on 5 and 25 March 2008, the Trust said that it had sought an independent view and had reached the conclusion that the psychiatrists had acted appropriately.

78 In relation to Ms A's concerns that care plans for Mr B had not been implemented and no one responded appropriately to the developing signs of risk to his physical and mental health, the Trust acknowledged that it failed to provide Mr B with an appropriate level of care and support.

The Council's position

79 In response to our enquiries, the Council said that in 2006, Mr B was receiving disability living allowance, income support and housing benefit. These were the benefits to which he was entitled, and the level of the benefits was automatically reviewed and confirmed on an annual basis. The CPN and support worker would have helped Mr B deal with that correspondence and access his benefits. Because there was no change to his financial circumstances, there would have been no need to refer him for additional benefits or welfare rights advice.

80 The Council's position in relation to the complaint that Mr B's care plan was not implemented and he did not receive the care and support to which he was entitled, is further explained by the evidence given at interviews with the Council's staff, which is attached to this report as an annex.

Specialist advice

Background clinical information

81 The GP Adviser provided some background information about myeloma and how this might have presented in the months before Mr B's admission to hospital. The GP Adviser said that myeloma is a form of blood cancer and that it is not common for GPs to diagnose new cases as there are only about 3,750 new cases in the UK annually.

82 The GP Adviser said that myeloma may present with:

- infections (due to altered immunity);
- anaemia (with symptoms such as tiredness, shortness of breath or palpitations);
- bone pain (where the tumour is eroding bone);
- pathological fractures (where the eroded bone is weakened and breaks);

- raised calcium (which may cause tiredness, weakness, loss of appetite, abdominal pain, kidney stones, nausea/vomiting, constipation or confusion);
- renal failure; and
- hyperviscosity of blood (slowing up of blood flow, so various blood clots may form which can cause confusion).

83 The GP Adviser said that consequently, myeloma may present in a dramatic way with perhaps a pathological fracture, or may be slow and insidious. If a patient had, for example, anaemia and raised calcium levels developing they might have experienced a rather non-specific decline with perhaps tiredness, loss of appetite and confusion. It is likely that there would have been a physical decline that had been going on for some months before diagnosis.

The advice of the Psychiatric Adviser

84 The Psychiatric Adviser examined the records relating to consultations Mr B had with psychiatrists on 5 and 25 March 2008.

85 The Psychiatric Adviser noted that a psychiatrist from the rapid access clinic saw Mr B on 5 March 2008. In his follow up letter to Mr B's GP, the psychiatrist noted Mr B's mental health deterioration: he showed increasing self neglect and paranoia. He commented that Mr B's family were concerned about self neglect and safety at home. He noted that Mr B had not been eating well and had lost a significant amount of weight. Mr B had not been letting his carers come into the house and his house was in a bad state. The Psychiatric Adviser noted that the current CPN had organised an occupational therapy assessment of his needs and that a care programme approach review had been arranged. The psychiatrist increased Mr B's prescription of Depixol (a drug used in the long-term management of schizophrenia) and also prescribed an antidepressant, fluoxetine.

86 The Psychiatric Adviser noted that Mr B, together with Ms A, saw a second psychiatrist on 25 March 2008. On 26 March the second psychiatrist wrote to Mr B's GP to say Mr B had shown some improvement in his mood and was no longer depressed, and had no psychotic symptoms. He identified the main problem as Mr B's physical disability following a period of severe self neglect including poor food intake. He asked the GP to screen his physical health. The Psychiatric Adviser said that this suggests that the second psychiatrist was asking the GP to take responsibility for looking after Mr B's physical health needs. It appears that the second psychiatrist did not think that there was an immediately life threatening situation but he did order blood tests.

87 The Psychiatric Adviser said that Mr B's medical records show that the psychiatrists who saw Mr B recorded Mr B's history and took note of Ms A's concerns. Treatment and investigations were arranged. A referral was made to Mr B's GP, who was the person best placed to conduct a review of Mr B's general physical health. The Psychiatric Adviser said that on the basis of the evidence available to her, it appeared that the standards set out in GMC guidance (paragraph 29) were met.

The advice of the Nursing Adviser

88 The Nursing Adviser said that records were kept separately by the support worker and the CPN. There was little evidence of communication between the two, and little reference to joint

reviews, joint visits or joint care plans. This was a fragmented system of record keeping, which made it harder to plan and deliver appropriate care. When Mr B's regular CPN was absent from work and a second CPN took over responsibility for him, she told Ms A on 13 March 2008 that she did not know that the community support team or Homecare staff were involved. The Nursing Adviser said that this fragmentation was not in line with the standards set out in the *Mental Health Policy Implementation Guide* (paragraph 27).

89 The Nursing Adviser noted that the individual records kept about Mr B were not always made promptly after visits; there were surprising gaps in the records, which became increasingly brief and uninformative through 2007 to early 2008. There was no depth to any assessment of Mr B's mental state, capacity or risk. While this level of detail is not to be expected from untrained support workers, it is to be expected of qualified professional staff such as the CPN. Records should have referred to Mr B's risk assessment and management plan. Had this been done, any need for change to the care plan would have showed. As it was not, it would have been difficult to form an overview of Mr B's ongoing status. The Nursing Adviser said that record keeping by the CPN did not meet the requirements of the NMC guidance (paragraphs 30 and 31).

90 The Nursing Adviser said that Mr B's care programme approach reviews did not take place as required by the *Mental Health Policy Implementation Guide* (paragraph 27). It appears that a care programme approach review meeting was held in November 2006. In the records, there was also a letter from a staff grade psychiatrist that referred to a care programme approach review which took place on 18 September 2007, but otherwise there is a gap in the care programme approach documentation until April 2008, by which time Mr B was in hospital. There is no evidence that all relevant people involved in Mr B's care were invited to reviews and his nearest relative was not involved.

91 The Nursing Adviser noted that a very thorough risk assessment had been drawn up by social services support staff in 2004, which was comprehensive in its detail and showed a good knowledge of Mr B. This was not updated but countersigned with the comment *'no change'* in 2005, 2006 and 2007. The Nursing Adviser said that a simple countersignature could not demonstrate an adequate review of Mr B's care plan and risk assessment. Moreover, while there is evidence that many of the triggers identified by this risk assessment were acted on, there were many occasions when they were not. This included, for example, the many occasions when Mr B avoided staff.

92 The Nursing Adviser said that there was evidence in the notes that Homecare staff and the support worker reported what they saw to their managers and that concerns were reported to the care co-ordinator, as required by the risk assessment and management plan. However, even where risks were identified, there is little evidence of appropriate action being taken by professional staff involved in Mr B's care. There seemed to have been an assumption that Mr B had at all times the capacity to make decisions in relation to his day-to-day life. Although concerns about Mr B's decision making were raised within the notes, there is no evidence that his capacity was ever formally tested, discussed or reviewed on a regular basis. For example, on one occasion when Homecare staff reported that Mr B had not been allowing them access, a manager went to the flat and gained access.

It seems that once it was established that Mr B was in the flat and alive and the flat was clean, little more was done. The Nursing Adviser said that Mr B's care workers (the CPN and support worker) seemed to be working in a culture which emphasised the individual's right to live in the way they chose. The Nursing Adviser said that from the evidence available, it did not appear that the care workers understood that this view must be balanced by regular consideration of an individual's capacity to make decisions.

93 In summary, the Nursing Adviser said that in their notes and conversations with each other, some staff had clearly raised concerns about Mr B's capacity to make decisions in relation to his self care and ability to feed, shop and protect himself from people who might take advantage of him. The problem was that no one took these issues up and responded to them within the framework of the *Mental Capacity Act 2005* or by considering the '*intervention threshold*' within the Trust's own vulnerable adults policy. Consequently, there was confusion as to the balance to be struck when considering whether Mr B had the capacity to make decisions.

94 The Nursing Adviser said that although staff clearly felt that they were giving Mr B a lot of practical support to live independently, he was often avoiding them: denying them access and essentially ignoring their suggestions. Mr B's increasingly odd behaviour and self neglect were ignored on the basis that he had the right to live in the manner he chose. The reality was that whereas Mr B might have been able to choose what he wanted to eat from a menu when in hospital, his mental state meant that he could not prioritise his physical needs against, for example, his desire to buy children's toys. It appeared that Mr B could be indifferent to his physical condition and deny any problems until the situation was quite serious.

95 The Nursing Adviser said that given the difficulty of engaging with Mr B, which was clearly increasing through 2007 to 2008, it is surprising that staff did not consider referring him to an assertive outreach team – a service designed for adults with a severe and persistent mental disorder who have difficulty maintaining lasting and consenting contact with services, particularly where there is significant risk of persistent self-harm or neglect. The Nursing Adviser also said that had public guardianship been considered, this would have allowed care workers to be more assertive about ensuring that cleaners had access and that Mr B had access to basic appliances such as a telephone, cooker and washing machine. Assistance with his finances could also have been better managed.

96 Finally, the Nursing Adviser raised a concern that Mr B's care was co-ordinated by a CPN who appeared to have too large a caseload (paragraph 27). When Mr B's cousin began to raise concerns about Mr B's care, and he began to show signs of significant physical illness, it seems that the CPN's managers were also slow to identify and react to the developing risk.

The Health Service Ombudsman's findings in relation to the complaint solely about the 5 Boroughs Partnership NHS Trust

97 Ms A's specific complaint solely about the Trust is that in March 2008 a psychiatrist failed to respond appropriately to Mr B's poor physical state; instead he prescribed inappropriate drugs for depression.

98 I have set out the standard expected of doctors when dealing with patients (paragraph 29);

doctors must adequately assess the patient's condition taking account of the history; provide or arrange investigations or treatment where necessary; and refer a patient to another practitioner, when this is in the patient's best interests.

99 Mr B saw two different psychiatrists on 5 and 25 March 2008. The Psychiatric Adviser has said that on both occasions, the psychiatrist commented on Mr B's mental and physical state and wrote to his GP indicating that he was self neglecting and losing weight. The first psychiatrist thought that he was depressed and his level of paranoia had increased; he prescribed increased Depixol and antidepressants. The second psychiatrist, three weeks later, thought that Mr B had improved in mood and had no psychotic symptoms. He ordered blood tests and specifically asked the GP to screen Mr B's physical health.

100 I have considered the evidence of Mr B's physical state in March 2008. By 15 March he was said to be having difficulty getting out of his chair and moving around; an assessment by the occupational therapist had been arranged. Despite daily visits from his cousin, who tried to ensure that he ate well, Mr B was still not improving physically or regaining weight. The second psychiatrist, who saw Mr B on 25 March, did not think that immediate hospital admission was necessary.

101 I agree that an admission for psychiatric reasons was not necessary at that time, and that the psychiatrist met the standards required by the GMC in assessing the patient, taking a history, taking account of his relative's concerns and referring him to the GP for investigation of his physical health. I note that there does not appear to have been any urgency in making that referral at a time when, by all accounts, Mr B's physical health was very poor and continuing to deteriorate despite the extra support he was receiving from his cousin. However, taking account of the Psychiatric Adviser's advice, I do not find that there was service failure in this regard.

The Local Government Ombudsman's findings in relation to the complaint solely about the Council

102 Ms A complained that no one supported Mr B to claim the benefits to which he was entitled.

103 I have found that when Mr B was referred to the CMHT, he was already receiving disability living allowance, income support and housing benefit. These were the benefits to which he was entitled. During 2006 to 2008 there was no change in Mr B's financial or personal circumstances and so there was no need for a review of the situation beyond the annual review and update carried out automatically.

104 There is evidence in the records that the CPN helped Mr B to apply for an independent living fund grant in order to buy a new bed, but this was refused. The CPN then helped him to apply for a loan, which he obtained in January 2008. The CPN and the support worker both regularly recorded that they accompanied Mr B to the Post Office in order to access his benefits.

105 I am satisfied that Mr B was receiving the benefits to which he was entitled and that the Council's staff helped him to access those benefits and apply for grants or loans as needed. I have found no service failure in this aspect of the complaint.

Our joint findings in relation to the complaint about both bodies which, through the community mental health team, had joint responsibility for managing Mr B's care plans

106 Ms A's complaint about both the Trust and the Council was that care plans were not implemented, and no one responded appropriately to the developing signs of risk to Mr B's physical and mental health. She has raised concerns about the cleaners, the support worker and the CPN. She is also concerned that when she herself tried to alert managers to Mr B's deteriorating state, still no action was taken.

107 In relation to this aspect of the complaint, we have considered whether the joint CMHT met the statutory requirements of the care programme approach and service standards published by the Department of Health (paragraphs 26 and 27). We have also considered whether the standards required by the NMC of nursing staff were met, and whether the Trust and the Council demonstrated that they had had regard to, and took account of, the *Mental Capacity Act 2005* and human rights considerations.

108 We first address Ms A's concerns about whether the Homecare service was providing the service it was required to. Ms A said that cleaners had claimed to have visited Mr B at times when he was not actually at home. We have seen the weekly timesheets prepared by the cleaners and signed by Mr B when they attended. The dates of the visits in February 2008 are given in the key events section of this report. There is no evidence that the cleaners claimed for visits when Mr B was not at home. We recognise that it would have been challenging to keep on top of the cleaning required at Mr B's flat, especially bearing in mind his reluctance to throw away rubbish and his repeated refusals of help. We also recognise that when Ms A saw the flat for the first time in February 2008, it was in a very squalid state which would have been very shocking to her. However, there is evidence that in 2007 and early 2008, cleaners repeatedly raised concerns about Mr B's living conditions. There is also evidence that failed visits were reported to the CPN, and that the Homecare manager became so concerned about repeated failed visits that she actively tried to discuss the service they provided with Mr B and his care co-ordinator, in order to better meet his needs. In short, we cannot see that there is robust evidence on which to base criticism of the Homecare cleaners; it appears that they did what they could and they raised concerns with managers, but that little action by appropriate professionals followed.

109 The evidence we have seen indicates that workers found it difficult to engage Mr B in ensuring that he cared for himself, ate reasonably well and kept his flat reasonably clean. Before 2007 there had been episodes when support workers had tried but failed to get him to visit the dentist despite his teeth being in a bad state, and had tried but failed to achieve treatment for the poor condition of his feet. There had been episodes when his flat had become excessively dirty and required extra cleaning. Efforts to persuade Mr B to move into accommodation with greater support available had been unsuccessful. Mr B was mentally unwell, had different ideas to many people and made what many would consider to be some unwise decisions. On the other hand, he was reported to take care over his appearance and to be out and about in the community, sometimes independently. Although he was identified as

being at risk of social isolation and self neglect, we have not seen evidence that, at least until mid-2007, he was unhappy, unkempt, or unduly isolated or that any of the concerns raised about his health or life style at that time were life threatening or that risks to his dignity or welfare were inadequately managed. That said, there were clear signs that Mr B was neglecting his own physical health. The failure to deal with the problems with his feet, for example, led to their becoming, by February 2008, very badly infected.

110 On examining the available evidence, it is possible to see significant changes occurring during 2007. Whereas Mr B had previously regularly been described as clean and smart in appearance, these comments no longer appeared in the records. There was the occasional comment about Mr B having been in bed or having just got up. At interview, both the support worker and the CPN identified a change in Mr B's habits, which they thought was possibly related to his trying to avoid contact not only with a neighbour he found troublesome but also with themselves. Both recognised that Mr B was becoming harder to make contact with: the number of failed visits increased. The Homecare service was particularly concerned about this and by December 2007, had specifically asked to review the level of cleaning support Mr B was given, as they felt they were not meeting his needs.

111 From later 2007 until early 2008, even before Ms A's intervention, there are indications that various concerns were being raised about Mr B's mental and physical state. These concerns were reported to the CPN who was the care co-ordinator. The Health Service Ombudsman's Nursing Adviser has pointed out that a care programme approach review meeting should have been arranged and that failing to do so was a missed opportunity. Such a meeting, involving everyone who was involved in Mr B's care, would have enabled an overall picture of developing risk to have emerged and been dealt with appropriately, perhaps by a referral to the assertive outreach team or, at the least, by a full review of the care package Mr B was receiving and a discussion about Mr B's capacity to make decisions about his own care. The Health Service Ombudsman's Nursing Adviser also said that a referral to the assertive outreach team should have been considered. He said that the service standards of the *Mental Health Policy Implementation Guide* were not being met; there was fragmented record keeping, a lack of care planning and review, and a failure to react to developing signs of risk.

112 The evidence of interviews indicated that the support worker and the CPN were strongly committed to supporting Mr B to live in the way he chose, without imposing decisions on him. For example, the CPN had thought that the pain of his developing foot condition would outweigh Mr B's fear of going to the doctor and he would be able to persuade Mr B to go at a later date. He described trying to help Mr B to make decisions '*without bullying him*'. The support worker told Ms A that he did not have the right to interfere in the way Mr B chose to live.

113 We acknowledge that Mr B's care workers wanted to respect his autonomy and independence. However, the risk assessment and management plan for Mr B identified very clearly the risks of self neglect. There was increasing evidence of self neglect. The management plan identified actions to be taken, which principally involved informing the CPN. Managers have confirmed that all concerns

would have been referred to the CPN and that it would have been for the CPN to take action or raise concerns during supervision. We have seen evidence that the CPN had a heavy caseload and was not keeping adequate records. He did not take appropriate action (such as calling a care programme approach review meeting, or considering a referral to the assertive outreach team). Guidance and supervision from his managers was not robust in ensuring that the CPN took appropriate action. We have noted that when Ms A attempted to contact the CMHT manager to alert him to the crisis that had developed in Mr B's care, there was little response.

114 In the Trust's and the Council's first written response to Ms A's complaint, they said that Mr B was '*a long standing, voluntary patient with capacity, entitled to reject assistance, which he did*'. It was not recognised that there had been no appropriate discussion or assessment of Mr B's capacity; consequently, the developing signs of risk to his physical and mental health were not recognised or acted upon appropriately. The CMHT failed to achieve the level of input Mr B required in order to maintain his health and acceptable living conditions, and thus did not meet their service standards.

115 We are not convinced by the Trust's and the Council's view, expressed in their first reply to Ms A, that Mr B interacted with them voluntarily and was capable of making considered decisions to refuse services. We have not seen robust evidence that Mr B's capacity to make decisions was ever seriously considered or that there was discussion about the balance to be struck between an individual's autonomy and dignity. Mr B's rights were clearly central in this matter but we have not seen evidence that the Trust or the Council had regard to or took specific account of human rights law or the provisions of the *Mental Capacity Act 2005* in making their decisions.

116 We consider that this accumulation of failings amounted to service failure.

Injustice

117 Ms A said that as a consequence of the neglect suffered by Mr B, his physical and mental health deteriorated. He was allowed to live in unacceptably squalid conditions. His physical health was allowed to deteriorate to the point where, when he was admitted to hospital with myeloma, his treatment was compromised by his poor condition and his chances of survival were seriously affected.

118 From the evidence we have seen, it appears that at the end of January 2008 Mr B had not begun to lose significant amounts of weight and was still sufficiently active to go out with the CPN to buy a bed and to move furniture in his flat to make room for it. Both the CPN and the support worker said that they had never been aware of faeces or urine stains or smells in the flat, although there were stains and it was grubby and untidy. During the first weeks of February there were many failed attempts by various services to contact Mr B, who turned up at Ms A's house on 15 February saying that he was unwell. By that time, from Ms A's account, the flat was in a very poor state, with faeces and urine, flies and insects very much in evidence.

119 It is understandable that Ms A, becoming newly involved in Mr B's care, should have thought that the conditions in which she found him in February 2008 were those that he had been

living in for a long time. However, the evidence does not support that view. We think it likely that Mr B's flat had always been in a state of relative untidiness and grubbiness that would be unacceptable to some people. On several occasions the cleaners called for extra assistance because it had become very dirty and action was taken by the Homecare service to clean it up. It seems likely, in view of Mr B's apparent greater neglect of his personal appearance in later months and the concerns raised by the Homecare service, that the state of his flat had worsened during late 2007 and early 2008. We have no doubt that Mr B had a poor diet. In February 2008 Mr B had a period of illness when he was unable to manage his own toileting needs, unable to get out to do any shopping, unable to clean up and refused access to everyone. Within a very short time, this would have had a very significant impact on Mr B and on the state of his flat.

120 It also appears that Mr B's deteriorating state was not wholly the consequence of self neglect. The Health Service Ombudsman's GP Adviser said that it is possible that a person with myeloma would have experienced a slow, insidious decline over the months before diagnosis, which would include increasing tiredness and confusion, loss of appetite and weight loss. There is evidence that Mr B was still physically active at the end of January 2008. After Ms A became involved in mid-February, Mr B began to receive regular visits from her; she took charge of his personal hygiene, diet and the cleaning of his flat. However, despite the greatly increased support provided by Ms A, Mr B continued to lose weight and to deteriorate physically. With hindsight, it is possible to see that Mr B had a serious illness which had not been diagnosed and which was significantly affecting his physical health.

121 After careful consideration of all the circumstances, we have reached the view that there was injustice to Mr B, as a consequence of the service failure we have identified. Over a period of time, insufficient contact was maintained and insufficient intervention was made so that Mr B's living conditions were allowed to deteriorate and his personal health to be neglected. This meant that when a crisis arose, in the period of illness he experienced at the beginning of February 2008, the CMHT was not in a position to identify the urgency of the problem and provide suitable assistance. Consequently, Mr B's condition quickly deteriorated to a wholly unacceptable state. However, we cannot definitely conclude that the outcome would have been significantly different, in terms of the diagnosis and treatment of his myeloma. But, while it appears that the illness itself contributed to Mr B's deterioration, we find that the failure to implement care plans and to manage risk appropriately also played a part.

122 We have also considered whether there was injustice to Ms A as a consequence of the service failure we have identified. Ms A was very distressed to find that her cousin was ill and living in very unsatisfactory circumstances. In the absence of help from the Trust and the Council, she worked hard to improve those conditions and to provide daily care for her cousin. She has also been put to considerable time and trouble to bring this complaint. We conclude that there was injustice to Ms A as well as to Mr B as a consequence of the service failure we have identified.

Ms A's response to the draft report

123 After we had sent a draft of this report to Ms A, her solicitors wrote to us on her behalf with comments which we carefully considered. There were two main points about our draft findings.

124 The first was that we had not criticised the psychiatrist although he had not made an urgent referral to the GP when Mr B was in very poor physical health. However, taking account of the sequence of events (outlined earlier in this report) and the view of the Health Service Ombudsman's Psychiatric Adviser, that the psychiatrist appeared to have acted in accordance with relevant standards and that the GP was best placed to review Mr B's general health, we remained of the view that the psychiatrist's actions appeared reasonable. We have commented on the psychiatrist's lack of urgency in making a referral, but did not conclude that that constituted service failure. We therefore concluded that the finding as it appeared in the draft report remained appropriate.

125 The solicitors said that we had reached a finding about the support Mr B received in claiming benefit without examining whether the original applications for benefit were correct. However, the complaint we have investigated was that no one had supported Mr B to claim the benefits to which he was entitled. Our investigation established that Mr B was in receipt of relevant benefits, and that staff had helped him to access and apply for those benefits and for other financial assistance. In the absence of any evidence that there was a particular omission in his benefits, it appeared to us that the finding in the draft report remained reasonable.

126 Finally, the solicitors said that we should have recommended that Ms A be compensated for her legal costs. After careful consideration of the representations made by the solicitors we agreed that a separate identified sum of £1,500 would be appropriate specifically in respect of the solicitors' costs in assisting Ms A to make her complaint. This sum, which we agreed should be paid directly to the solicitors, is in addition to the financial redress amounting to £2,000 which we recommend should be paid to Ms A.

Conclusions

127 Taking account of all the evidence available to us, in relation to the joint complaint about both bodies that had joint responsibility for managing Mr B's care, we have found service failure and injustice as a consequence of that service failure. We therefore uphold this main aspect of Ms A's complaint. We have not found service failure with regard to Ms A's separate specific complaints about the Trust or the Council.

Recommendations

128 Taking account of the injustice suffered by Mr B and Ms A, we recommend that the Trust and the Council should, within one month of the date of issue of this final report on the investigation, write to Ms A to acknowledge the service failure we have identified and apologise for the impact this had on Mr B. The Trust should also apologise for the distress this caused her and the time and trouble she was put to in supporting Mr B and in making this complaint. The circumstances of this case would, in our view, have justified a substantial financial remedy for Mr B, had he survived. In recognition of the distress caused to Ms A, the efforts she

made to provide appropriate care for Mr B in the weeks before his admission to hospital, and the time and trouble she has been put to in pursuing this complaint, we recommend that the Trust and the Council should provide compensation to Ms A of £2,000. We also recommend that the Trust and the Council should pay £1,500 directly to Ms A's solicitors specifically in respect of the representations which they have provided.

129 We further recommend that the Trust and the Council should, within three months of the date of this final report, prepare an action plan which describes what each has done to ensure that they have learnt the lessons from the failings identified by this upheld complaint; and what they have done and/or plan to do, including timescales, to avoid a recurrence of these failings in the future. Copies of the action plan should be shared with Ms A, the Health Service and the Local Government Ombudsmen, NHS Halton and St Helens (the commissioning primary care trust), NHS North West (the strategic health authority), the Care Quality Commission and Monitor. The regulators, the commissioning primary care trust and the strategic health authority should be kept informed of progress against the action plan.

Section 4: Final remarks

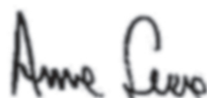
130 In this report we have set out the evidence we have considered, the advice we have obtained and our findings, conclusions and decisions with regard to the service Mr B received from the Council and the Trust.

131 We have not found that the Trust's psychiatrist failed to provide appropriate care to Mr B, or that the Council failed to support Mr B in claiming appropriate benefits. However, we found that the Trust and the Council failed in their joint responsibility to manage and implement care plans for Mr B and to take adequate account of developing signs of risk. This was service failure, which contributed to the injustice of unnecessary pain and neglect experienced by Mr B and to the distress and trouble for his cousin, Ms A. Therefore, we uphold the complaint about the Trust and the Council.

132 We have proposed remedies including apologies and financial compensation and action to improve matters for future service users. We are satisfied that these proposals will be a satisfactory resolution of the complaint. The Trust and the Council have agreed to our recommendations.

133 We hope this report will provide Ms A with the explanations she seeks. We can reassure her that lessons will be learnt and the learning shared as a result of her complaint so that others are now less likely to suffer the same experiences. We also hope that this report will draw what has been a long and complex complaints process to a close.

Ann Abraham
Health Service Ombudsman



Anne Seex
Local Government Ombudsman

June 2011

Annex

The evidence from interviews

The community psychiatric nurse (CPN)

1 The CPN said that his workload had generally been between 40 and 50 cases, with a mix of simple, moderate and complex cases. In his role as CPN (care co-ordinator), he had provided a mixed bag of activities and practical support for service users, aiming to develop therapeutic relationships. The role of CPN, however, was more like a 'team captain' who had to marshal others. Mr B had quite a large group of people working with him – the CPN, support worker and the personal care service.

2 The CPN said that his main role was to monitor Mr B's mental health. There were often difficulties getting access. He had to give Mr B an injection of 100mgs Depixol every two weeks. The CPN felt that Mr B's mental health was relatively stable and he had not noticed a deterioration over time. Mr B had seemed to deliberately evade the CPN at times, and the CPN had varied the times to call in order to catch him.

3 The CPN said that Mr B's flat was always in disarray, but it was possible to sit and have a reasonable conversation with him. He was always orientated to time, person and place. He was eccentric, or odd. He could draw, and enjoyed doing so, but had never wanted to go to an art group. He did not have overt delusional ideas, but if questioned it would emerge that Mr B was concerned that the police were X-raying his teeth and that he felt he was part of the royal family. The CPN would chat to get an indication of how intense Mr B's delusions were and his mood. He said that he did not believe that Mr B would ever be symptom-free. Mr B had fixed and firm ideas. He had never seen Mr B in extreme distress or even unhappy. He considered whether Mr B had been depressed when he had last seen him, and thought probably not.

4 The CPN said that Mr B had made decisions that other people might regard as unwise. He would not buy a microwave oven – he preferred to buy food that he could heat up in a pan. He did have burgers, which were microwaved at the shop where he bought them. He adapted to and survived in his own environment. It was not easy to push him to choose a different diet. He always had lots of tea, with sugar and milk. There were always mounds of teabags in the kitchen.

5 The CPN said that there had been problems with Mr B's feet and that they had managed to get him to the hospital but the operation was cancelled. The support worker had reported that Mr B had refused to go again. The CPN said that the condition of Mr B's feet was not life threatening. He had thought that he would be able to persuade Mr B to go back to the doctor when the discomfort outweighed his fear of the hospital and doctors.

6 The CPN had last seen Mr B at the end of January 2008. He had thought that they were making progress. He had been trying to persuade Mr B for some months to get a new bed because his bed had collapsed – he was still sleeping on it on the floor. They had got a loan and Mr B had agreed to get a new bed and bed linen. They had gone together to make the purchases and Mr B was looking forward to its delivery; he had cleared space in his flat for it.

7 The CPN said that he had tried a 'drip drip' approach – engaging with Mr B, developing a therapeutic relationship, in order to help him

make choices. He felt that in some areas he had had some success but he accepted that Mr B's choices were often not wise. He had considered whether, given information, Mr B could make use of that information to make choices. He had tried to feed information to help Mr B make good choices, but without bullying him. Mr B had understood the consequences of his decisions. It had been difficult to know how to proceed differently. In some ways, it felt like being between a rock and a hard place, trying to find ways for him to stay independent and live his life in the way he wanted. He did not think that at the end of January 2008, he had reached the point where he could do no more for Mr B.

8 The CPN said that he was very surprised by Ms A's complaint about the state of the flat. He acknowledged that the flat was in disarray and there were toys everywhere. It was not the cleanest, but it was also not the dirtiest he had seen. The furniture was stained with spilt tea, and was grubby, but he had never seen or smelt urine or faeces anywhere. The CPN had first met Mr B in 1988 – he was always pale and skinny. He had administered his injection every fortnight – Mr B had always fully dropped his trousers and he had always been skinny, but he did not appear to have significant weight loss over time, up to the end of January 2008.

9 The CPN said that Mr B had liked to dress smartly, with a tie and jacket. Later, he had tended to get up a bit later and sometimes appeared a bit dishevelled in the mornings. The CPN thought that Mr B might have been trying to avoid another service user who sometimes used to come round and beg money from him. When they went out together, Mr B had walked fast; the CPN had never noticed that his feet or back caused him problems moving around. Sometimes he was a little stiff; he had a past spinal injury. Mr B had always appeared comfortable sitting and had always gone to the door to see him out at the end of a visit. If Mr B had been in any pain from movement, the CPN thought that he would have noticed it.

10 The CPN said that he had struggled to keep up with paperwork. He had a heavy caseload and had tried to spend as much time as he could with people. He said that he recognised that this left him less time for record keeping and he acknowledged that he had not kept records to an appropriate standard.

11 The CPN said he had one-to-one supervision with his manager, usually monthly, but it could vary. This was a formal opportunity to raise problems. There were also team meetings. Generally, the CPN felt that he just had to get on with things. It seemed that they would often get new services users allocated to the team, but there did not seem to be ways to discharge them. He had felt that he should be coping.

The support worker

12 The support worker said that Mr B had liked to do things at night. He used to go out independently. He was often seen out and about on his own. Mr B had liked to look smart and spent money on smart clothes. He was always clean shaven and used to wear a collar and tie. He had a bit of a phobia about the supermarket – he thought there were '*villains*' there – so he liked to do his shopping in the local corner shop.

13 The support worker said that Mr B liked to get sandwiches or cook 'boil in a bag' meals. Generally, Mr B had not liked to put the central heating on; he preferred to sit wrapped up in a blanket.

14 The support worker said that he had suspected Mr B was abused in the community – he could be persuaded to pass money on, as he thought it was his Christian duty to help others. He suspected that at times, Mr B had allowed a homeless man to sleep in his flat. He was strange about other people in his flat – he would invite them in but then suddenly ask them to leave. He was always untidy but would clear up occasionally. There were times when extra cleaners had to be called in, but Mr B did not like them to move his things around and had asked them to leave.

15 The support worker said that when Mr B had problems with his feet, he had done what he could. He had got him to the hospital twice, but the operation had been cancelled. The third time, Mr B had refused to go. The CPN had said he would sort it. They had tried to persuade Mr B to go into a care home, or even a warden-controlled flat, but he had consistently refused.

16 The support worker said that he had noticed a change over time; from 2006 to 2007, it seemed that Mr B was harder to engage. He refused visits, becoming more withdrawn and often seeming tired. He did not think Mr B was depressed. He had delusions but you could still have reasonable conversations with him.

17 The support worker said that he had supervision with his manager about once every four to six weeks. He always discussed Mr B's case. If he had concerns, he reported them on to the CPN. They kept separate notes but they worked in the same building so he could leave notes for him asking to speak or recording his concerns. His manager had also raised his concerns with the CPN. If he was away, he would contact his manager.

The community mental health team manager

18 The CMHT team manager said that his team (CMHT South), covered the largest population and the most deprived areas of St Helens. It was a big team and very busy. It was an integrated team of social workers and CPNs. His key responsibilities were to manage his team's caseloads and ensure that policies were adhered to. Management policies, induction and training were different for the Trust's and the Council's employees.

19 The CMHT team manager said that his team was too large for him to be able to directly supervise all members. CPNs were on two grades. He met the senior CPNs monthly, to discuss their caseload and identify any concerns. The senior CPNs then supported the more junior staff – CPNs and healthcare assistants. It was the responsibility for CPNs to identify their own needs for training and set it up. The senior CPNs had a caseload of about 30 to 40 service users. There was an expectation that they would be able to identify concerns and raise them in supervision.

20 The CMHT team manager said that the CPN was a very experienced senior case worker. He had always been willing to accept new cases but was not as successful in disengaging or referring them on. He had a heavy caseload. As care co-ordinator, concerns about his service users raised by other workers would always be reported to him. It was the CPN's responsibility to raise concerns in supervision or informally, if necessary. Staff kept their own files and these were separate from those of the support service.

21 The CMHT team manager said that Mr B had been referred to the CMHT from the assertive outreach team and had a significant package of care. As Mr B became more difficult to engage, there should have been a review and perhaps a referral back to the assertive outreach team. For that to have happened, Mr B's records would have had to be fully up to date. The CMHT team manager said that he was aware that the CPN had had difficulty with record keeping.

22 The CMHT team manager said that the CPN was a very kind man and very caring. He said that the CPN was very committed to the care of those for whom he was responsible and was not neglectful. The CPN, and other members of the team, had held a strong view that people had the right and should be supported to live in the way they chose. Social workers had received more training on issues relating to capacity to make decisions than had CPNs. He felt that in Mr B's case, a social worker might have been more questioning about whether Mr B had the capacity to make reasonable decisions about his own care. In general, the team did not make much use of Guardianship (paragraph 25 of the report) – only three of their service users were at present under Guardianship.

23 The CMHT team manager said that, in February 2009, the CPN had begun a long term absence and, as his manager, he had asked another CPN to review all of the CPN's cases. The new CPN had seen Mr B at Ms A's house and had raised some concerns about Mr B's care. It appeared that Mr B's physical health deteriorated rapidly from February onwards.

24 The CMHT team manager said that the Trust's policy on the protection of vulnerable adults in place at that time was quite hard to use. It focused on abuse by others, rather than self neglect. It appeared that in the hierarchy of risk, neglect always seemed to be regarded as lower risk.

25 The CMHT team manager said that he met his manager for supervision monthly. As part of that, he would discuss any concerns about his team members.

The personal care services manager

26 The personal care services manager said that she was the manager of the team providing personal care services for Mr B. When she joined the team in December 2007, this had been a care package providing two people to clean for one hour per week. She became aware almost immediately that her team were very concerned about Mr B – the state of the property he lived in and his personal state. The flat was very dirty, there was often a lot of rubbish in the flat, fast food and pies. It was dark and there were flies. The bed was in a bad state. She had known Mr B from a long time before and knew that his standards were different, but she felt that things had deteriorated. He himself was unkempt, unshaven and grubby. The personal care services manager said that many visits by cleaning staff failed but that on every occasion that the cleaners were not able to obtain access to the flat, this was reported to the CPN.

27 The personal care services manager had made an appointment to make a joint visit to Mr B with the CPN on 7 January 2008 because of her concerns that the care package was not sufficient. She had felt that it would be better for just one cleaner to go more often as this would better enable a relationship to develop. The CPN had said he would deal with the matter but then was absent from work.

28 The personal care services manager said that she was aware that the team were not meeting Mr B's needs. She had wanted to do a reassessment of Mr B's needs, which the CPN had been willing to arrange. She had been very disappointed when she had been informed that their services were no longer required.

The community mental health services manager

29 The community mental health services manager said that at the time of this complaint, he had had overall responsibility for the three CMHTs and also managed the person who had had responsibility for the provision of support services.

30 The community mental health services manager said that he believed that within the CMHTs, the management arrangement of formal monthly supervision of staff and informal contact, when necessary, was potentially robust enough to deal with emergencies and complex contingencies that arose. Since the time of the complaint, new systems of audit had strengthened the process.

31 The community mental health services manager said that having both social workers and CPNs, employed by the Council and the Trust, sometimes meant that there were differences in the nature and level of training they received. This may have been the case with regard to issues of capacity. The teams had a strong sense that people had a right to live in the way they chose. The Council's and the Trust's policies relating to the protection of vulnerable adults were not always helpful, particularly when the risk to be assessed was that of self neglect. There was a changing policy framework at that time. Staff had a broad understanding of issues of capacity but there was a tendency for the CPNs to think that capacity should be assessed by a psychiatrist. They had a good understanding of the *Mental Health Act 1983*, but did not always consider the potential to use the *Mental Capacity Act 2005* when the threshold for use of the *Mental Health Act 1983* was not met. Since the time of the complaint, the Council and the Trust have undertaken a wave of training in this area.

32 The community mental health services manager said that there were tensions trying to reconcile service users' right to choice and control with the right to live with personal dignity. He did not believe that there was ever any intention to neglect Mr B; he thought that the care workers involved had cared and done their best for him, but that they may have got the balance wrong. As concerns accumulated, a professionals' meeting should have been held to review and discuss Mr B's case. Such a review might not have provided easy answers, but would have shared the responsibility more widely.

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0300 061 4102
phso.enquiries@ombudsman.org.uk

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Parliamentary and Health Service Ombudsman

Millbank Tower
Millbank
London SW1P 4QP

Tel: 0345 015 4033
Fax: 0300 061 4000
Email: phso.enquiries@ombudsman.org.uk

www.ombudsman.org.uk

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