Local Government
OMBUDSMAN

Parliamentary
and Health Service
Ombudsman

# Report of two investigations by the Local Government Ombudsman for England and the Health Service Ombudsman for England

HC 447

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# Contents

# Foreword

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

One complaint is about Barnet, Enfield and Haringey Mental Health NHS Trust, Barnet and Chase Farm Hospitals NHS Trust and Enfield Council. The complaint was made by Ms I[1] about the care provided to her late brother.

The second complaint is about the North East London Mental Health Trust (now known as the North East London NHS Foundation Trust) and Havering Council. The complaint was made by Mr S about the care provided to his late wife.

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

**Ann Abraham**
Parliamentary and Health Service Ombudsman

March 2010

[1] The identities of the complainants and their families have been anonymised in the report.

# Summary

These are the reports of two cases which we have jointly investigated, both of which involve the provision of services by a local council and by NHS trusts – and both, to some extent, concern the actions of staff working in mental health services.

The first complaint, made by Ms I, was that in the period shortly before his death, and while he was living in sheltered accommodation managed by Enfield Council, her brother became ill and, because of failings by the Council's staff and by staff employed by Barnet, Enfield and Haringey Mental Health Trust and by Barnet and Chase Farm Hospitals NHS Trust, he died. Having considered all the relevant available evidence, and the views of professional advisers about treatment by Accident and Emergency staff, and by Mr I's Consultant Psychiatrist, we did not conclude that there had been service failure on the part of the two NHS bodies. We found that Council staff had not adhered to their own processes in connection with sheltered housing residents becoming ill, and had not notified Mr I's family about his illness. To that extent we concluded that there had been maladministration on the part of the Council. However, since we could not conclude that that maladministration led to the injustice which Ms I had claimed (Mr I's subsequent death) we did not uphold the complaint.

The second complaint, made by Mr S, was about the care and treatment of his late wife, who had dementia. He complained that Havering Council had failed to provide sufficient support for his wife prior to her compulsory admission to hospital under the *Mental Health Act* which, he claimed, had been inappropriately arranged by a social worker employed by the Council. He also complained about the way the Council had handled his subsequent complaint about these matters. Finally, he complained about the care provided to Mrs S when she was in the hospital, which was managed by the North East London Mental Health Trust (now known as the North East London NHS Foundation Trust). Although we had some concerns about the handling of Mr S's complaint by the Council, these were not so serious in our view as to amount to maladministration; neither did we find that there had been maladministration by the Council in the substantive aspects of Mr S's complaint. We did not therefore uphold any part of the complaint against the Council. As for Mrs S's care in hospital, where she had a fall subsequently necessitating the surgery elsewhere, and following which she died, we had concerns about the assessment of her risk of falling by the Trust staff; there was also a failure to keep Mr S properly informed. Having taken account of the relevant evidence and after taking advice from both Nursing and Medical Advisers, we concluded that these failings did amount to service failure and that they led to injustice: Mrs S's need for surgery might have been prevented had a risk assessment taken place and safeguarding measures been in place; and Mr S was caused distress about the level of care which his wife received. We therefore partly upheld the complaint against the Trust.

Health Service Commissioners Act 1993
Local Government Act 1974

Report by the Health Service Ombudsman for England and
the Local Government Ombudsman for England
of an investigation into a complaint made by Ms I

Complaint about:
Barnet and Chase Farm Hospitals NHS Trust,
Barnet, Enfield and Haringey Mental Health NHS Trust
and Enfield Council

# Section 1: Introduction

1 Ms I's complaints span the remits of the Health Service Ombudsman and the Local Government Ombudsman. Using provisions in their respective statutes, both Ombudsmen agreed that a joint investigation leading to the production of joint conclusions in one report seemed most appropriate. Ms I agreed to this approach.

## The complaints

2 Ms I has complained about care and treatment provided to her late brother, Mr I. Mr I lived in sheltered housing and had schizophrenia which was treated with medication. On 11 December 2006, some time after the medication had been changed by his consultant psychiatrist (who was employed by Barnet, Enfield and Haringey Mental Health NHS Trust – the Mental Health Trust), an ambulance was called for Mr I as he was experiencing back pain and shortness of breath. The ambulance took him to the Accident and Emergency Department (A&E) of Chase Farm Hospital, part of Barnet and Chase Farm Hospitals NHS Trust (the Hospital Trust). The staff from his sheltered housing complex did not accompany him. He was examined and then discharged home where sadly, on 15 December 2006, he died. Mr I died of a pulmonary embolus and deep vein thrombosis.[2]

3 Ms I has said that failings in the care and treatment her brother received at A&E, the changes to his psychiatric medication and a lack of support from staff at the sheltered housing all contributed to his death. She also complained that she was not told about her brother's admission to A&E until after his death and that staff from the sheltered housing should have informed her about what was happening to her brother; Ms I says that if she had known that her brother was unwell she could have intervened to help – especially as the nature of his schizophrenia meant that he would have had difficulties communicating his needs.

4 Ms I wanted to know what happened to her brother and to find out if the family's belief – that failures by Enfield Council's (the Council's) sheltered housing staff and the actions of the Hospital Trust and the Mental Health Trust contributed to his death – were correct. She complained to the Mental Health Trust, the Hospital Trust and the Council but was dissatisfied with their responses.

5 She then complained to the Healthcare Commission, who did not uphold her complaint that Mr I should have been admitted to hospital from A&E.

6 Ms I has said that she found the complaints process difficult to follow and unsatisfactory in explaining what had happened to her brother.

## The Ombudsmen's remit, jurisdiction and powers

### General remit of the Health Service Ombudsman

7 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

[2] Deep vein thrombosis is a blood clot in a vein, usually a leg vein. The common cause is immobility. A complication occurs in some cases where part of the blood clot breaks off and travels to the lung; this is known as a pulmonary embolus.

providers such as GPs, and independent persons (individuals or bodies) providing a service on behalf of the NHS.

8 When considering complaints about an NHS body, she may look at 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.

9 Failure or maladministration may arise from action of the body itself, a person employed by or acting on behalf of the body, or a person to whom the body has delegated any functions.

10 The Health Service Ombudsman may carry out an investigation in any manner which, to her, seems appropriate in the circumstances of the case and in particular may make such enquiries and obtain such information from such persons as she thinks fit.

11 If the Health Service Ombudsman finds that service failure or maladministration has resulted in an injustice, she will uphold the complaint. If the resulting injustice is unremedied, she may recommend redress to remedy any injustice she has found.

### Health Service Ombudsman – premature complaints

12 Section 4(5) of the *Health Service Commissioners Act 1993* states that the Health Service Ombudsman may not generally investigate any complaint until the NHS complaints procedure has been exhausted. However, section 4(5) makes it clear that if, in the particular circumstances of any case, the Ombudsman considers it is not reasonable to expect the complainant to have followed the NHS complaints procedure, she may accept the case for investigation. This is a matter for the Ombudsman's discretion after consideration of the facts of the case.

13 Here, the Health Service Ombudsman noted that Ms I had experienced considerable difficulties in trying to follow the complaints process for each of her complaints; and also that, as the complaints were all interrelated, in order to provide a seamless response that would fully address them, a joint investigation with the Local Government Ombudsman would be appropriate.

## General remit of the Local Government Ombudsman

14 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 (local councils) and certain other public bodies. He may investigate complaints about most council matters, including Social Services and the provision of social care.

15 If the Local Government Ombudsman finds that maladministration has resulted in an unremedied injustice, he will uphold the complaint and may recommend redress to remedy any injustice he has found.

### Local Government Ombudsman – premature complaints

16 By section 26(5)(a) of the *Local Government Act 1974* (as amended), the Local Government Ombudsman may not generally entertain a

complaint unless satisfied that it has been brought to the notice of the council concerned and that the council has had a reasonable opportunity to investigate the complaint and reply to the complainant.

17 However, section 26(5)(b) makes it clear that if, in the particular circumstances of any case, it is not reasonable to expect the complainant to take the complaint to the council, the Local Government Ombudsman may accept the case for investigation.

18 In this instance (where Ms I's complaint had been treated as an enquiry by the Council) the Local Government Ombudsman exercised that discretion and accepted the case for investigation, in order to carry out the investigation jointly with the Health Service Ombudsman.

## Powers to investigate and report jointly

19 The *Regulatory Reform (Collaboration etc. between Ombudsmen) Order 2007* clarified the powers of both 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. In this case, the Health Service Ombudsman and the Local Government Ombudsman agreed to work together because the health and social care issues were so closely linked.

## This investigation

20 During this investigation we have considered comments and papers provided by the Hospital Trust and the Mental Health Trust, including their complaints files and copies of Mr I's medical records, and policies on the prescribing of medication. (The papers did not include a prescription or administration record for Mr I's psychiatric medications which would have provided detailed evidence of the dosages and frequency of administration of the medications.) However, the Council provided copies of papers relating to the day-to-day care of Mr I, copies of assessments and copies of its policies and procedures. We have also considered comments provided by Ms I and her son.

21 We obtained specialist advice from two professional advisers: Dr T Malpass FRCP DCH, a consultant in emergency medicine (the A&E Adviser), and Dr N J R Evans MA BM Bch FRCPsych, a consultant psychiatrist (the Psychiatric Adviser). The Professional Advisers are specialists in their field and in their roles as our advisers they are completely independent of any NHS body. The draft report was shared with Ms I, the Hospital Trust, the Mental Health Trust and the Council. Their comments on the provisional findings were considered.

22 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 overlooked.

## Summary of our decisions

23 Having considered all the available evidence related to Ms I's complaint, including her recollections and views, her comments on the draft report and the comments of the bodies under investigation, and having taken account of the clinical advice we have received, we have reached the following decisions.

24 The Health Service Ombudsman does not uphold Ms I's complaints about the Mental Health Trust or the Hospital Trust.

25 The Local Government Ombudsman finds that there was maladministration by the Council but that it did not result in injustice in this instance.

# Section 2:
# The basis for our determination of the complaint

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

27 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.

28 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.

29 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.

30 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.

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

## The general standard

32 In February 2009 the Health Service Ombudsman republished three sets of principles outlining the approach public bodies should adopt in order to deliver good administration and how to respond when things go wrong. The *Ombudsman's Principles* comprises of: the *Principles of Good Administration*, *Principles for Remedy* and *Principles of Good Complaint Handling*.

33 The same six key Principles apply to each:

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

34 We have taken these Principles into account in our consideration of Ms I's complaint.[3]

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

## Specific standards

### National guidance and good practice

#### British National Formulary

35 The British National Formulary (BNF) reflects current best practice as well as legal and professional guidelines relating to the use of medicines. It details all medicines that are generally prescribed in the UK, with special reference to their uses, cautions, contraindications, side-effects, dosage and relative costs. It is intended for use by prescribers in the NHS as well as by pharmacists, nurses and other healthcare professionals and is compiled with the advice of clinical experts. It is an essential reference providing up-to-date guidance on prescribing, dispensing and administering medicines.

36 Modecate is listed in the BNF as an antipsychotic medication; the recommended dose range falls between 12.5mg and 100mg to be given at intervals of 14 to 35 days. Artane is an anticholinergic drug commonly prescribed in dosages of 5mg, 2 or 3 times daily. The BNF advises against abrupt withdrawal of anticholinergic drugs.

#### The British Thoracic Society guidelines

37 These guidelines[4] set out the practical approach to the management of suspected pulmonary embolus. Of significance to this complaint the guidelines say that a negative D-dimer test (a type of blood test) reliably excludes the possibility of pulmonary embolus in patients with a low or intermediate pre-test probability.

### Local guidance

#### Relevant extracts from Enfield Council's *Sheltered Housing Manual*

***Section 4 (8): Hospital Admission Forms (Home blocks only)***

38 *'The forms should be completed when the tenant moves in, checked and regularly updated. The forms should be kept in the Blue Bag in the office.*

*'These forms should be sent with the tenant if they have to go to hospital, ensuring the hospital has the full information on the tenant.*

*'In extra care schemes, carers also have copies of the hospital forms.'*

***Section 4 (10): Tenant Risk Assessments***

39 *'Needs and Risk Assessments are carried out for all Sheltered Housing tenants. The assessments are carried out using the following guidelines ... 6. If a critical incident occurs the Risk Assessment must be revised within 24 hours, if a tenant is experiencing a general decline in health.'*

***Section 4 (14): Outside Agencies***

40 Part 5: *'Relatives – contacted for issues relating the following areas. Any relevant change in circumstances, for example well being of tenant. All contact must be recorded.'*

[4] British Thoracic Society guidelines for the management of suspected acute pulmonary embolism. Thorax 2003; 58:470–484 http://www.brit-thoracic.org.uk/Portals/0/Clinical%20Information/Pulmonary%20Embolism/Guidelines/PulmonaryEmbolismJUN03.pdf

## In-house *Home Care Service Staff Handbook* (Enfield Council, January 2005)

41 This handbook provided guidance to extra care staff who assisted tenants in their own homes. Section 2.2 of the handbook stated that staff were *'to encourage and assist service users* [tenants] *to achieve an optimum level of independence'* and section 3.2, entitled *Autonomy and Independence*, said that *'service users must be enabled to make decisions in relation to their own lives, providing information, assistance and support where needed'*.

# Section 3: The investigation

## Background and key events

42 Mr I was under the care of his local mental health team, where he was seen regularly by his Community Psychiatric Nurse (CPN) and reviewed by his Consultant Psychiatrist. Mr I was prescribed medication to treat schizophrenia in the form of long-acting injections of an antipsychotic (depot Modecate) and a daily anticholinergic tablet (Artane) to relieve side-effects of the antipsychotic.

43 As part of Mr I's care and treatment, he received support with activities of daily living via sheltered housing. The sheltered housing complex provided a service to older adults which had two components: 'housing' (matters connected with tenancy and maintaining tenancy); and 'extra care' (care staff to assist tenants with activities of daily living). Mr I received both types of service and required assistance with daily living activities. Staff were available on site during the day and a member of staff slept on site at night and was available to tenants in an emergency. Tenants also had access to the Enfield Community Alarm, a system for triggering an alarm to seek emergency support via a call centre.

44 Mr I's CPN wrote a letter to his GP which was received on 26 January 2006. The CPN said that Mr I's mood tended to deteriorate a week before his depot was due and asked whether his medication could be reviewed, suggesting that the time interval between each depot be reduced from four to three weeks.

45 On 28 March 2006 a review meeting was held at the sheltered housing complex, attended by Mr I's CPN, his Consultant Psychiatrist, staff from the sheltered housing complex, Ms I and another of Mr I's sisters.

46 On 8 April 2006 the Consultant Psychiatrist wrote to Mr I's GP with details of the review meeting. She explained that Mr I was generally settled but had some difficulties sleeping. She suggested a new management plan: to stop Artane and start Zopiclone (a sleeping tablet) and to continue his depot medication at 25mg every three weeks. She also said that she would arrange for Mr I's care to be transferred to another mental health team, as the sheltered housing was not in her catchment area.

47 GP records indicate that a prescription for Zopiclone was first issued for Mr I on 1 June 2006 and that the last prescription for Artane was issued on 2 August 2006.

48 Mr I's care was transferred to another community mental health team within the same Trust. His new consultant psychiatrist wrote to the GP on 11 September 2006 saying that he had been doing extremely well and that he remained stable on his depot injections, which should continue.

49 In the early morning of 11 December 2006 Mr I was experiencing back pain that was affecting his breathing. He was with a carer from the sheltered housing complex when the emergency alarm was pulled at 3.27am; an operator from Enfield Community Alarm called an ambulance and Mr I was taken to Chase Farm Hospital's A&E department.

50 Mr I was seen by a triage nurse at 4.10am who took details of his condition and prioritised his care. He then underwent a series of tests including temperature, pulse, respirations and oxygen saturation and his urine was also tested. He was given oxygen and sent to have a chest X-ray.

51 At 7.00am Mr I was admitted to the Observation Ward where further tests and examinations were carried out. These included taking a medical history and repeat tests of those noted in the previous paragraph. Additionally, an examination of the cardiovascular system was also carried out which included a D-dimer test.[5] Other examinations of the respiratory and neurological systems and the lower limbs were carried out.

52 The examinations carried out in A&E and the Observation Ward did not show that Mr I had a pulmonary embolism or deep vein thrombosis – the D-dimer test returned negative. It was considered that Mr I was suffering with back pain and worsening of his shortness of breath caused by chronic obstructive pulmonary disease (COPD).[6] He was discharged home with painkillers and a letter to his GP requesting a lung function test.

53 Mr I returned to the sheltered housing complex; he had some painkillers and a carer took the letter to the GP Practice.

54 On Tuesday 12 December 2006 carers reported that Mr I was still experiencing back pain. He was asked whether he would like to see his GP but declined saying that he would carry on taking his painkillers. The carer negotiated with Mr I that if he was no better by the Thursday then they would see the GP.

55 On 14 December 2006 Mr I was still in pain and he agreed to see his GP. The GP carried out a home visit and prescribed more painkillers and lactulose (a laxative). Mr I was advised to stop taking Paracetamol and Zopiclone for a few days and if he was still no better, to call the GP again.

56 On 15 December 2006 at approximately 2.30pm carers documented that Mr I was sitting on his bed resting and that he spoke to them. The carers documented that they returned to the flat at 3.30pm but did not see Mr I. At 4.00pm the carers went back to the flat where they discovered that Mr I had died.

## Ms I's complaint about the Mental Health Trust

57 Ms I complained that:

- Mr I's long-acting antipsychotic medication (depot Modecate) was administered at incorrect time intervals; and
- Mr I's anticholinergic medication (Artane) to control the side-effects of his depot (Modecate) was abruptly stopped and that without it, her brother would shake, his speech would be slurred and he would have a *'panic attack'*.

58 Ms I believed that these factors affected her brother's health and contributed to his death.

### The Mental Health Trust's comments

59 We offered the Mental Health Trust the opportunity to comment on Ms I's complaint at the outset of the investigation. We also shared

[5] D-dimer test: a blood test that is used to screen for abnormal clot formation such as deep vein thrombosis and pulmonary embolus. Combined with a risk assessment, a negative result signifies that a deep vein thrombosis/pulmonary embolus is highly unlikely to be present.

[6] COPD: a long-standing disease in which lungs have been damaged, often associated with smoking, and free flow of air into the lung passages is restricted. It may produce coughing, wheezing and breathlessness.

the draft report with the Mental Health Trust to provide them with an opportunity to comment on the provisional findings of our investigation.

60 The Mental Health Trust provided comments from the Consultant Psychiatrist who said that she recalled that she had discussed the medication changes with Mr I and his two sisters and that they had all been in agreement with the changes at the time. She also said that prescribing practice had changed since Mr I had first been diagnosed, and that she had stopped Artane as it was not indicated in elderly patients and should only be used in cases of severe extra-pyramidal side-effects (EPSE).[7]

61 The Mental Health Trust also said that they had offered to meet Ms I after she complained but that she had not taken up this offer, and that this was unfortunate as they might have been able to allay her concerns.

62 The Mental Health Trust were unable to tell us who was responsible for prescribing or administering Mr I's depot medication; the Mental Health Trust said that they thought that Mr I's GP had been responsible for administering the depot. They could not locate any prescriptions or evidence of administration of the depot. (Mr I's GP provided us with records of all medication that had been prescribed by the GP Practice in the twelve months prior to his death. The GP informed us that the Mental Health Trust had been responsible for the prescription and administration of the depot and therefore her records did not contain any information about this.)

## The advice of our Psychiatric Adviser

63 Our Psychiatric Adviser has studied the medical records provided by the Mental Health Trust. He commented that they show that, overall, the care and treatment given to Mr I by the Mental Health Trust seemed appropriate and reasonable. Our Adviser added that Mr I was looked after by community psychiatric nurses and consultant psychiatrists in a standard scheme of care and that his transfers between services, such as from adult to geriatric, and from one catchment area to another, were smoothly managed.

64 On the issue of medication our Psychiatric Adviser has said that the mainstays of psychiatric treatment are antipsychotic drugs, often continued through life, but that this did not imply that the dose would remain fixed. The psychiatric medication that Mr I was taking was within a range that was reasonable for his condition and age (according to BNF guidance, paragraphs 35 and 36).

65 Our Psychiatric Adviser reviewed out-patient letters from 1984 onwards, and noted that Mr I normally and sensibly self-medicated his Artane: meaning that he took the medication as and when he experienced the side-effects that it was prescribed to counteract. The Adviser noted that Mr I had been taking a relatively low dose – 5mg daily. He could not find any evidence that Mr I was experiencing side-effects that required Artane in the months leading up to his death and so considers that it was appropriate and correct to stop the medication. He said that it is safe to stop this medication immediately, and that he would not have expected there to be any relevant physical consequences to this

[7] EPSE – these are side-effects of antipsychotic medication which cause movement disorders such as stiffness and shaking or other abnormal involuntary movements.

other than that which was desired – improved sleep – where the dosage was low. He also noted that Mr I had been accustomed to adjusting his own dose, including stopping it altogether, in the past.

66 Turning to the complaint about the time interval between the depot medication, as explained in paragraph 62, neither the GP nor the Mental Health Trust were able to provide prescription or administration records and therefore our Psychiatric Adviser was unable from these sources to establish the dose and interval between depots at the time of Mr I's death. However, documents provided by the Council show that Mr I's CPN visited him to administer his depot and our Adviser has also seen out-patient records where dose and frequency of medications are detailed. These records suggest that the dose and time interval between Mr I's depot medication were altered on occasions according to psychiatric signs and symptoms. So, for example, in 1984 when his mental state was considered to have deteriorated the records state that he was given 25mg of Modecate every three weeks and that he remained on this dose. However, as his mental state improved and he was considered to be *'consistently stable'* in July 2004, this was reduced to 12.5mg every four weeks. Again in January 2006, when his CPN noted that Mr I's mood deteriorated in the week before the depot was due, it was increased to 12.5mg every three weeks.

67 Our Psychiatric Adviser has said that with any medication, doctors should not continue with something that is no longer required or with a larger dose than is necessary and that all doctors should be vigilant for opportunities to stop or reduce medications. On the basis of Mr I's medical records and the other evidence obtained in this investigation, our Adviser considered that the prescribing practice was reasonable and fell within the appropriate dose range as outlined in the BNF (paragraphs 35 and 36).

### The Health Service Ombudsman's findings in relation to the Mental Health Trust

68 Having considered the available evidence and after taking account of the advice provided by the Psychiatric Adviser, I am satisfied that the changes to Mr I's medication were reasonable. The adjustments to his medication (including the most recent one) were appropriately considered and there is no evidence to connect the changes in his medication, or other aspects of his psychiatric care, with his sudden death. Therefore, I find that there was no service failure in this regard.

## Ms I's complaint about the Hospital Trust

69 Ms I complained that:

- Mr I was not able to communicate his health problems effectively due to his chronic schizophrenia and therefore staff at the A&E department should not have relied upon his statements; and

- had Mr I been admitted to hospital then he might not have died.

### The Hospital Trust's comments

70 We offered the Hospital Trust the opportunity to comment on Ms I's complaint at the outset of this investigation. We also shared the draft report with the Hospital Trust to provide

them with an opportunity to comment on the provisional findings of our investigation. The Hospital Trust did not provide any comments, but produced all the evidence and papers requested. These included copies of medical records and papers relating to the attempted local resolution of Ms I's complaint.

## The advice of our Accident and Emergency Adviser

71 The A&E Adviser has studied the medical records provided by the Hospital Trust and the complaint file which accompanied it. She has advised that the documented history taken from Mr I and the examinations and investigations that were carried out on him were *'impressively thorough'*.

72 The A&E Adviser has commented that staff working in A&E departments are usually trained to deal with patients who may not be able to give a clear history and that, as the sheltered housing staff had not accompanied Mr I to hospital, this probably would have been taken as an indication of his ability to cope independently. She noted that a detailed history was taken and staff would have had no particular reason to doubt the accuracy of what Mr I had said to them.

73 The A&E Adviser has commented that it is clear that A&E staff were aware that Mr I was taking Paracetamol and Zopiclone; however, there is no reference in the medical records to his psychiatric medication. She said that the psychiatric medications were unrelated to and would not have been influenced by his presenting complaint (breathlessness and back pain).

74 The A&E Adviser has also clarified the basis of Mr I's admission to the Observation Ward; this was not a general ward but an acute assessment ward designed for admission of patients whilst initial investigation and assessments are made. The Adviser said that Mr I was seen by an orthopaedic team for his back pain; they could find no serious cause for his pain and considered that he could be discharged. He was also seen by the physicians and a physiotherapist who, in addition to the tests carried out (which included a negative D-dimer test), also considered Mr I's suitability for out-patient management. The A&E Adviser noted that this represented a thorough and efficient clinical care pathway in line with British Thoracic Society guidelines and that Mr I's clinical management at A&E was reasonable. The A&E Adviser said that it was reasonable for Mr I to be discharged from the Observation Ward, based on the results of the examinations and investigations, at that time.

## The Health Service Ombudsman's findings in relation to the Hospital Trust

75 Having taken into consideration the A&E Adviser's comments, I conclude that the care and treatment that Mr I received at the A&E department was reasonable. Staff at A&E were able to take a full and appropriate medical history from Mr I, which demonstrates that he was able to communicate effectively to them. Appropriate tests and examinations were carried out, including a negative result of a D-dimer test, which ruled out pulmonary embolus/deep vein thrombosis at the time. On that basis, it was considered that Mr I could be discharged to the care of his GP and his symptoms managed as an out-patient, and there was no need to keep him in hospital any longer. I am satisfied that the care and treatment provided to Mr I did not fall

below a reasonable standard. I therefore find no service failure in this regard.

## Ms I's complaint about the Council

76 Ms I complains that:

- the staff at the sheltered housing scheme should have accompanied her brother to attend A&E; and
- the staff at the sheltered housing scheme should have informed Mr I's family that Mr I had been taken to A&E in an ambulance.

77 Ms I told our Investigator that she visited her brother at the sheltered housing scheme every week and that the staff there would telephone her and her husband *'all the time for silly little things'*; yet, she complained, although her brother had been unwell and taken to A&E by ambulance, the staff did not inform her of this important news until after his death. Ms I said that had she known about his ill health, she and her husband would have taken Mr I to A&E and helped him to explain his difficulties.

## The Council's response to our enquiries

78 We wrote to the Council to offer it the opportunity to comment on Ms I's complaint at the outset of the investigation. The Council provided all the evidence and papers requested. We noted that the sheltered housing service aimed to secure the independence and autonomy of individuals in its care. We also noted the Council's initial response to Ms I's complaint, in which it had said that Mr I had asked staff not to contact his family when he was taken by ambulance as it was too early in the morning.

79 The Council was sent a draft copy of this report, and its comments on our provisional findings have been taken into account.

## The Local Government Ombudsman's findings in relation to the Council

80 I have noted that the sheltered housing staff worked with tenants to maintain their independent living skills and their autonomy by encouraging them to achieve an optimum level of independence in accordance with assessed care needs. Within this context, I consider that it was not unreasonable that a carer did not accompany Mr I to A&E as he was considered to be independent to mobilise and access facilities. I also note that the records show that Mr I specifically asked staff not to call his family as he did not wish to disturb them. In the Council's response to the draft report it said relevant staff had been interviewed and they confirmed that Mr I said he did not want his family contacted. I consider that it was appropriate for staff to respect Mr I's autonomy by accepting his decision at that time. There may have come a point when Mr I's wishes would have been overridden, but I am satisfied that it was reasonable for staff not to have contacted Ms I and the Council was not at fault.

81 There are no records to show that two relevant policies were adhered to. The sheltered housing complex's form for hospital admissions did not go to A&E with Mr I (paragraph 38). In addition, the sheltered housing complex's *Tenant Risk Assessment* was not completed (paragraph 39).

82 In commenting on the draft report of this investigation, the Council said that the staff were aware of the *Hospital Admission Form* procedure and that all those interviewed said the form would have been sent to the hospital with Mr I. There is no record of the form being sent.

83 I cannot say for certain that the form was sent, but that there is no record of this is a fault in itself. However, as the fault is in relation to record keeping I find that this did not cause any injustice to Ms I.

84 In response to the draft report of this investigation, the Council accepted that the *Tenant Risk Assessment* should have been completed. It refers to other documents – the *FACE Overview Assessment*, the *Sheltered Housing Support Plan* and the *Living Skills Assessment* – where Mr I's risks and health and safety issues were considered. But I note that these documents do not refer to any **new** potential risks after his visit to hospital. He was still unwell after he came back to the home and an assessment of this new risk should have been undertaken. Having said all that, however, based on the Advisers' comments, and the Health Service Ombudsman's findings about the Hospital Trust and the Mental Health Trust, I acknowledge that even if these procedures had been carried out, there is no reason to believe that the eventual outcome would have differed.

85 I consider that the Council's failure to record sending a *Hospital Admission Form* with Mr I to A&E and its failure to update risk assessments amounts to maladministration.

## Ms I's comments on our findings

86 After we had sent her a copy of this report in draft form, setting out our provisional findings, Ms I, with her son, expressed her dissatisfaction with a number of our conclusions. In particular:

- she suggested that her brother's symptoms were indicative of a rare condition known as Neuroleptic Malignant Syndrome. Having taken professional advice we concluded that there was no evidence to support that hypothesis;

- she maintained her view that there was a failure to diagnose Mr I's condition which stemmed from the Council's staff's failure to complete appropriate paperwork, accompany him to hospital or inform his family; and

- she suggested that the main consequence of failing to inform her at the time was that concerns which she would have had about his symptoms could not be taken into account. In response to these last two points, we have concluded that reasonable medical oversight at the time did not point to an imminently fatal condition.

## Injustice

87 Having taken into account the advice provided by our Professional Advisers in relation to the care provided by the Mental Health Trust and the Hospital Trust, we do not consider that the failings identified here in respect of the Council contributed to Mr I's death. We conclude, therefore, that the specific injustice claimed (that an opportunity for his family to intervene to help ensure that Mr I received appropriate

care was missed) did not result from the maladministration identified.

## The complaints about the Mental Health Trust, the Hospital Trust and the Council: our joint conclusions

88 Our investigation into the Mental Health Trust and the Hospital Trust leads us to conclude that their care and treatment of Mr I was reasonable. The psychiatric medications that Mr I was taking, including the changes in dosage and time intervals, were reasonable for his age and condition: the medication (including the cessation of Artane) would not have contributed to his death. The investigations carried out by the Hospital Trust were thorough and included a test to diagnose deep vein thrombosis and at the time there was no indication to admit Mr I. We find no service failure by the Mental Health Trust or the Hospital Trust. The Health Service Ombudsman therefore does **not uphold** the complaints about the Mental Health Trust or the Hospital Trust.

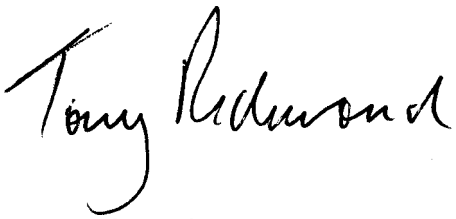
89 We have found that the service provided to Mr I by the Council's staff fell below a reasonable standard and that this amounted to **maladministration**. The Council failed to follow its internal policies: to record whether a hospital form accompanied Mr I to A&E and to update the tenant risk assessment. However, we found that no serious injustice resulted directly and so the Local Government Ombudsman finds that there was maladministration by the Council, but that it did not result in injustice.

# Section 4: Concluding remarks

90 In this report we have set out our investigation, findings and conclusions with regard to the care, treatment and service Mr I received from the Mental Health Trust, the Hospital Trust and the Council. We are aware that our findings about the care and treatment provided by the Trusts will be disappointing for Ms I, who, in her comments on our draft report, expressed her disagreement with our findings, and her firm view that Mr I might have survived had she been informed of his ill health in time. We would like to assure her that her complaints have been thoroughly and impartially investigated and that our conclusions have been drawn from careful consideration of detailed evidence, including the opinion of independent professional advisers.

91 We therefore hope that this report will provide Ms I and her family with at least some of the explanations they were seeking and assure them of our firm view that the clinical care and treatment that Mr I received was of a reasonable standard and would not have contributed to his death.

Ann Abraham
**Health Service Ombudsman for England**



Tony Redmond
**Local Government Ombudsman**

March 2010

Health Service Commissioners Act 1993
Local Government Act 1974

Report by the Health Service Ombudsman for England and
the Local Government Ombudsman for England
of an investigation into a complaint made by Mr S

Complaint about:
The London Borough of Havering and
the North East London Mental Health Trust
(now known as the North East London NHS Foundation Trust)

# Section 1: Introduction

1 This report sets out our findings and conclusions with regard to our joint investigation into Mr S's complaints about the London Borough of Havering (the Council) and the North East London Mental Health Trust (the Trust).

## The complaint

2 Mr S complained that: the Council failed to provide appropriate residential care for his wife prior to her second detention, in April 2006, under Section 3 of the *Mental Health Act 1983* (the MHA); as a result of this failure she was then detained (sectioned) wrongly under the MHA and taken to a hospital to which he thought it had been agreed she would not be admitted again, following a previous period of detention there in December 2005; and, whilst she was being assessed at that hospital she suffered a fall which resulted in a broken hip. (Mrs S was later transferred to another hospital where she died. The events at the second hospital were the subject of a separate complaint, not investigated here, which was the subject of ongoing discussion between Mr S and the relevant Trust at the time of this investigation.) We have summarised the headings of complaint in this report as follows:

(a): The adequacy and appropriateness of the help and support Mr S received from the Council prior to his wife's further detention under the MHA.

(b): The reasonableness and legality of Mrs S's compulsory detention under the MHA on 28 April 2006.

(c): The Council's response to Mr S's complaint.

(d): The Trust's care for Mrs S at Mascalls Park Hospital.

3 Mr S felt that he had not had answers to all his concerns about the level of care provided for his wife, and he hoped that the Ombudsmen's investigation would provide this information. He also hoped that the outcome of his complaint would be that other people would not go through the same experience.

## The Local Government Ombudsman's remit

4 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 (local councils) and certain other public bodies. He may investigate complaints about most council matters, including the delivery of Social Services and the provision of adult social care.

5 If the Local Government Ombudsman finds that maladministration has resulted in an unremedied injustice, he will uphold the complaint and recommend appropriate redress.

### Local Government Ombudsman – out of time complaints

6 The Local Government Ombudsman does not normally investigate matters of which the complainant was aware and that have happened more than twelve months before they complained to the Council. But the Local Government Ombudsman can use his discretion to investigate earlier events (Section 26B of the *Local Government Act 1974* (as amended)).

7 Mr and Mrs S had been in contact with the Council's adult care services since at least December 2004. Mr S did not make a complaint to the Council until July 2007. It decided to investigate matters that took place after the sectioning in April 2006. Mr S's complaint to the Local Government Ombudsman was made in October 2007. The Local Government Ombudsman has exercised his discretion to look at matters since January 2006, as this provides the background to how Mrs S came to be detained.

## 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 When considering complaints about an NHS body, she may look at 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.

10 If the Health Service Ombudsman 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*[1] she may recommend redress.

## Health Service Ombudsman – premature complaints

11 Section 4(5) of the *Health Service Commissioners Act 1993*, as amended, states that the Health Service Ombudsman may not generally investigate any complaint until the NHS complaints procedure has been invoked and exhausted.

12 However, section 4(5) also makes clear that if, in the particular circumstances of any case, the Health Service Ombudsman considers it is not reasonable to expect the complainant to have involved and exhausted the NHS complaints procedure, she may accept the case for investigation in any event. This is a matter for the Ombudsman's discretion after proper consideration of the facts of each case.

13 In this instance, the Trust appeared to have had a reasonable opportunity of providing Mr S with a response to his concerns and it seemed that there was little probability of a better outcome being achieved through a further attempt at local resolution. Taking these matters into account, the Health Service Ombudsman exercised her discretion to investigate the complaint about the Trust.

14 During our investigation it became apparent that Mr S also wished to complain about the actions of a second Trust, which managed the hospital to which his wife was transferred after her fall and in whose care she died. In this instance as the NHS complaints procedure had not been exhausted and the second Trust considered that it might be able to resolve matters, the Health Service Ombudsman decided not to exercise her discretion to investigate Mr S's complaint about the second Trust. Instead, she referred

[1] *Principles for Remedy* is available at www.ombudsman.org.uk

that complaint back to the Trust for further action (paragraph 2).

## Powers to investigate and report jointly

15 The *Regulatory Reform (Collaboration etc. between Ombudsmen) Order 2007* enabled 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 fell within the remit of both Ombudsmen.

16 In this case, the Health Service Ombudsman and the Local Government Ombudsman 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.

## Our investigation

17 During the investigation our staff met Mr S to ensure we had a full understanding of the nature of his complaint. Our staff also interviewed the Approved Social Worker (ASW) who had sectioned Mrs S. Relevant documentation about the case was examined including both the Council's adult care records and the Trust's clinical records. The Trust and the Council also provided additional information in response to our specific enquiries, in particular details of the Council's procedure for compulsory hospital admission and the Trust's December 2007 policy on falls.

18 We obtained specialist advice from Ms L Onslow MSc BA (Hons) RN, a Nursing Adviser with expertise in the care of older people (the Nursing Adviser), and Dr Charles Turton MB BS MD FRCP, a consultant physician (the Medical Adviser). The Professional Advisers are specialists in their field and in their roles as our advisers they are independent of any NHS body or local authority.

19 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 overlooked.

20 A draft of this report was sent to the Council, the Trust and Mr S, and their comments have been taken into account in this final version.

## Summary of our decision

21 Having considered all the available evidence related to Mr S's complaint, including his recollections and views, and having taken account of the clinical advice we have received, we do not find maladministration or service failure in respect of the provision of services by the Council to Mr and Mrs S prior to Mrs S's detention under the MHA. Neither do we find procedural fault with the way in which the decision was taken to detain her under the MHA on 28 April 2006. Although some concerns have been identified regarding the Council's handling of Mr S's complaint, these do not amount to maladministration. We therefore do not uphold the complaint about the Council.

22 In terms of Mrs S's care whilst she was being detained in hospital we find service failure, both in terms of the assessment of her risk of

falling and in the Trust's communication with Mr S about her fall. This led to injustice to Mrs S, in that it is possible that if she had had an appropriate assessment her fall might have been prevented, and she might not then have needed surgery; and to Mr S, because of the distress caused by this contribution to his overall perception of inadequate care by the Trust for his wife. We therefore uphold this aspect of Mr S's complaint about the Trust.

23 There were also service failures in that the Trust failed to undertake an adequate examination immediately after the fall; failed to undertake an adequate investigation into the fall; and their record keeping was generally poor. This does give rise to concerns about the Trust's procedures in respect of, and record keeping about, patient falls, but these service failures by the Trust did not lead directly to injustice to Mr or Mrs S.

24 In this report we explain the detailed reasons for our decisions and comment on the particular areas where Mr S has expressed concerns to the Ombudsmen.

# Section 2:
# The basis for our determination of the complaint

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

26 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.

27 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.

28 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.

29 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.

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

## The general standard

31 In February 2009 the Health Service Ombudsman republished three sets of principles outlining the approach public bodies should adopt in order to deliver good administration and how to respond when things go wrong. The *Ombudsman's Principles* comprise of: the *Principles of Good Administration*, *Principles for Remedy* and *Principles of Good Complaint Handling*.

32 The same six key Principles apply to each:

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

33 We have taken these Principles into account in our consideration of Mr S's complaint.[2]

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

## Specific standards

### Legislation

34 The *National Health Service Act 1977* places a duty on the NHS to promote services to improve health. Section 1 of the Act confers a duty on the Secretary of State to secure improvements in the physical and mental health of the population. Section 22 creates a duty of co-operation between NHS bodies and local authorities in exercising their respective functions.

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

36 The MHA is mainly concerned with the responsibilities of NHS trusts, and local authorities with social service functions, towards people who are considered to need compulsory assessment, treatment, or care due to poor or fragile mental health. Local authorities with social service functions are required to appoint ASWs (social workers with appropriate competence) to make assessments and, where appropriate, applications for compulsory admissions to hospital or to guardianship.[3] In November 2008 ASWs were renamed Appropriate Mental Health Professionals, but this report refers to them by the title in use at the time of the events complained of.

37 The most common applications sought by ASWs under the MHA are:

- applications for admission for assessment under Section 2 of the MHA; or
- applications for admission for treatment under Section 3 of the MHA.

38 Such applications are commonly referred to as 'sectioning'. In making these applications ASWs must comply with the provisions of the MHA and its associated *Code of Practice* which, among other things, require them to:

- interview 'patients' in a 'suitable manner';[4]
- satisfy themselves that detaining a 'patient' in hospital is the most appropriate way of providing the care and medical treatment needed;[5] and
- in the case of an application for admission for assessment, take steps to inform the 'nearest relative' that the application is to be made or has been made.[6]

39 Before making an application for admission the ASW must interview the patient and assess the availability and suitability of other means of giving the patient appropriate care and medical treatment, and take the least restrictive option. In coming to a decision the ASW must take into account the medical opinion of two doctors

[3] MHA, Section 114.
[4] MHA, Section 23(2).
[5] MHA, Section 13(2).
[6] MHA, Section 11(3).

who have examined the patient. One of these doctors should have had previous acquaintance with the patient and one doctor must be approved by the Secretary of State under Section 12 of the MHA. Generally, this is not part of doctors' duties under their National Health Service contracts, and so their actions in making such assessments are not within the jurisdiction of the Health Service Ombudsman.

40 Although the MHA describes the administrative functions ASWs should perform, it does not prescribe how they should assess a patient. The 2006 Department of Health guidance on Social Services complaints[7] says that a decision regarding the making of an application under the MHA is an action taken independently of the local authority and therefore falls outside the complaints procedure. Taken together, this means that ASWs act in a 'personal capacity' when they are carrying out their functions under the MHA. In deciding whether to make an application for compulsory admission they are not acting here on behalf of a local authority. So whilst the Local Government Ombudsman cannot consider the merits of ASWs' decisions, in terms of whether or not they should have sought an application for admission for assessment or treatment, he can consider their actions leading up to and immediately after the decision to apply for a 'section'. The Local Government Ombudsman may therefore consider the way in which the ASWs go about making their assessments, and how they deal with related matters such as:

- conveying the patient to hospital;
- arranging for their home and/or property to be made secure; and
- any necessary referrals or arrangements for the welfare of any children or dependants of the patient.

41 The Health Service Ombudsman may investigate an NHS trust's care for a patient so admitted.

## National guidance

42 In a circular[8] the Department of Health reminded councils of their duties under section 47 of the *NHS and Community Care Act 1990* and said that they should develop strategies to fill gaps and improve the range, accessibility and effectiveness of adult social care services. The circular says that prior to admission to adult care, a Care Plan should be developed and agreed with the individual. There should be a written record of a Care Plan that should encompass as a minimum:

- a note of eligible needs;
- the preferred outcome of service provision;
- contingency plans to manage emergency changes; and
- a review date.

43 The *National Service Framework for mental health: Modern Standards and Service Models* (referred to here as the *NSF for Mental Health*), issued by the Department of Health in 1999, reiterated the importance of the Care Programme Approach (CPA) as a means of systematically assessing an individual's health and social care needs and for drawing up plans to address those needs. The CPA required close

[7] *Learning From Complaints – Social Services Complaints Procedure for Adults*, paragraph 2.3.2.
[8] LAC (2003) 13, *Fair access to care services: guidance on eligibility criteria for adult social care.*

working between health and Social Services and the involvement of users and carers. It stressed the need for anticipatory planning to enable better decision making at times of change and to try to avoid crisis.

44 Amongst the document's *'key messages'* are:

> *'Ensure individuals and their carers are actively engaged in the planning and delivery of their care.*
>
> ...
>
> *'Agree, operate and performance manage a joint discharge policy that facilitates effective multidisciplinary working at ward level and between organisations.*
>
> *'On admission, identify those individuals who may have additional health, social and/or housing needs to be met before they can leave hospital and target them for extra support.*
>
> ...
>
> *'Consider how an integrated discharge planning team can be developed to provide specialist discharge planning support to the patient and multidisciplinary team.'*

45 Appendices 5.6 and 5.7 of the *NSF for Mental Health* specifically address the needs of people with learning disabilities, mental health problems or dementia. The importance of meeting the special needs of these groups of patients by effective multidisciplinary and multi-agency working is a recurrent theme of the guidance.

46 In 2001 the Department of Health published the *National Service Framework for Older People* (the *NSF for Older People*). This set out standards for the care of older people in the following eight areas:

- the elimination of age discrimination;
- person-centred care;
- intermediate care;
- general hospital care;
- stroke;
- falls;
- mental health in older people; and
- the promotion of health and active life in older age.

47 In respect of falls, the aim of the guidance (Standard 6 of the *NSF for Older People*) was to reduce the number of incidents that result in serious injury and ensure effective treatment and rehabilitation for those who had experienced falls. A cornerstone of this standard was the completion of a comprehensive assessment to establish the risks associated with an older person's admission to hospital. NHS trusts were expected to develop and implement local policies that ensured compliance with the benchmark standards.

48 In *Making a Difference: strengthening the nursing, midwifery and health visiting contribution to health and healthcare* (Making a Difference), issued in 1999 by the Department of Health, the Chief Nursing Officer identified a need to focus on the fundamentals of nursing care. This led to the development of a set of benchmarking tools known as *The Essence of Care: Patient-focused benchmarking for health care practitioners* (the Essence of Care), Department of Health, 2001.

At the time of this complaint benchmarking tools were available for eight areas including:

- food and nutrition;
- personal hygiene and mouth care;
- continence and bladder and bowel care;
- record keeping;
- safety of patients with mental health needs;
- privacy and dignity; and
- communication.

49 NHS trusts are encouraged to utilise the benchmarking tool as a basis for sharing, comparing and improving practice.

## Professional standards

50 The Nursing and Midwifery Council's (NMC's) *The Code: Standards of conduct, performance and ethics for nurses and midwives* (2004) provides overarching guidelines relating to keeping patients and/or their families informed of events such as falls as soon as they occur (paragraph 116). The NMC has also identified record keeping as a fundamental part of care (paragraph 126).

## Local guidance

51 The Trust told us that they had no specific falls management policy in place at the time of the events in question. However, we were informed that falls risk screening was an integral part of the Trust's *Clinical Risk Assessment and Management Policy* (2005) and that in December 2007 the Trust implemented this *Falls Management Policy*.

# Section 3: The investigation

## Background to the events

52 The following information is included by way of background. (These matters are not under investigation here, as they happened too long before the complaint was made to the Council – paragraph 7 – and we express no views, positive or negative, on what happened.)

53 Mr and Mrs S were a self-sufficient couple who had been married for 55 years. In late 2004 Mrs S began to show signs of dementia and grew increasingly anxious when Mr S left their flat without her. Mr S contacted the Council for advice and support. From December 2004 a 'homecare package' was arranged of half an hour each weekday to help Mrs S with her personal care, medication, and breakfast. In addition a sitting service was provided from 11.00am to 3.00pm on Wednesdays whereby a carer would keep Mrs S company whilst Mr S went shopping. At the end of February 2005 Mr S said he no longer wanted help from Social Services and so the homecare package was brought to an end.

54 In May 2005 Mr S asked the Council again for assistance. The social worker (the Social Worker) involved offered to arrange for a carer to visit but Mr S rejected this, saying that his wife would not like it; but after further contact he agreed. In June 2005 a new homecare package was arranged which aimed to support Mr S in his efforts to ensure that Mrs S could remain living in her own home. The package consisted of the attendance of a carer for half an hour a day for five days a week, to help Mrs S with her personal care and breakfast, as well as one hour's sitting service on Tuesdays and Thursdays so that Mr S could go shopping.

55 In June 2005 Mrs S's Consultant Psychiatrist wrote to the couple's Social Worker suggesting that Mr and Mrs S be re-housed in a warden-controlled flat as a means of providing some additional support to enable them to continue living together, as Mrs S had made it clear that she did not want to go into residential care without her husband.

56 In August 2005 the Social Worker noted that the burden of co-ordinating his wife's round-the-clock care was taking its toll on Mr S. She noted that *'day care/respite ...'* had been offered to Mr S but he had refused to take up the offer. As the existing support services seemed to be working well, and as the situation seemed stable, the Social Worker ended her involvement in the case. When doing so she wrote to the Council's Housing Manager with the suggestion that Mr and Mrs S be re-housed in a warden-controlled flat.

57 Mrs S became increasingly anxious and in December 2005 was detained for assessment in Mascalls Park Hospital under Section 2 of the MHA. While in hospital she had a fall, apparently from her bed in the early morning, and incurred a relatively minor cut to the back of her head. Her status was later downgraded to 'informal' – whereby her attendance was no longer compulsory – and so she was allowed home on leave for Christmas. Mr S did not return her to the ward and as her status was now voluntary the Trust discharged her.

## The Ombudsmen's investigation into the actions of the Council and its Approved Social Worker

58 Having outlined the background, we will now say more about the key subsequent events associated with each aspect of the complaint.

## Complaint (a): the help and support Mr S received from the Council prior to his wife's further detention under the MHA

59 Mr S said that the Council did not provide him with the help and assistance he needed for his wife's care at home and that the Council did not support him by finding an appropriate residential care setting for Mrs S prior to her detention under the MHA.

### Key events as recorded by the Council leading up to Mrs S's detention under the MHA on 28 April 2006

60 Following Mrs S's discharge from Mascalls Park Hospital after her December 2005 detention, the Council reinstated the support programme of a carer visiting for half an hour five days a week for Mrs S's personal care with an additional hour's sitting service on Tuesdays and Thursdays; a total of four and a half hours. This arrangement worked well and Mrs S – who usually became very agitated when women called to see her husband – got on well with the female carer in this instance.

61 In late February 2006 Mr S twice contacted the Council, saying that his wife's condition was worsening and he was having difficulty in caring for her. He declined an offer of a visit, saying it would upset Mrs S. It was suggested to Mr S that he visit the local Community Dementia Centre to seek advice, with a view to his wife attending the Centre in future.

62 On 14 March 2006 a second Social Worker followed up by calling Mr S to ask if matters had improved. This Social Worker has said that Mr S claimed that all was well. He was offered respite care, by means of Mrs S being admitted to Mascalls Park Hospital to give him a break, but said that they both disliked the Hospital. On 16 March 2006 a call was received from the Dementia Centre explaining that Mr S had been in contact to say that he could not manage: in a telephone conversation of 14 March, he had said that his wife was refusing to consider any help or assistance; she was refusing to take her medication. He felt that residential care was needed but was certain that Mrs S would refuse to go. He wanted her assessed.

63 On 20 March 2006 Mrs S's Consultant wrote to the Council to ask for a social worker to be allocated, saying:

> *'in the future there will be a need for serious consideration of either emergency respite or residential care or even a guardianship order ...'*

By the time the letter arrived a social worker had formally been allocated the case and the assessment process had begun.

64 The Social Worker visited to complete an assessment of Mr and Mrs S's needs. As a result, the support programme was increased from 18 April 2006 onwards by half an hour's additional 'sitting service' on Tuesdays and Wednesdays (a total of five and a half hours), so giving Mr S additional respite time to go out without his wife. Mr S has said that the initial result of the Social Worker's assessment visit was an actual reduction in the number of hours of support as opposed to the Council's assertion that they were increased. The Council's records show that Mr S is quite correct on this point as, for a few days, there was some confusion over the number of hours to be provided, but this appears to have been quickly resolved. We have not seen any evidence that Mrs S did not

receive the appropriate number of visits after these initial difficulties.

65 On 7 April 2006 a worker from the Dementia Centre called a duty social worker asking if residential care could be considered for Mrs S as Mr S had telephoned the Centre asking for assistance and exhibiting signs of stress. This message was passed on to the allocated Social Worker. There is no record of what action was taken in response.

66 On 23 April 2006 Mr S contacted the Council about Mrs S wandering outdoors during the night. The Council's records say Mr S said she had been knocking on neighbours' doors in a state of undress. Mr S is recorded as having said he could no longer cope and wanted residential accommodation for his wife. The next day a social worker visited with a Community Psychiatric Nurse. She noted that Mrs S was very agitated and had been refusing her medication. Mrs S pushed her husband and raised her fists to him. The Social Worker and the Nurse explained that they could not take Mrs S into residential care against her will. Mr S said he did not want her to be sectioned. He said he felt additional home care would not help them as Mrs S would only allow the present carer into the flat and no one else. The Social Worker noted that Mr S said he was thinking of leaving his wife as he could not cope any more.

## Mr S's recollection of the events leading up to his wife's detention under the MHA

67 Mr S says that he felt it was his duty as her husband to care for his wife. He had asked for her to go into residential accommodation but she did not want to move from her home or go into care without him. Her Consultant had recommended warden-controlled housing (paragraph 56) after Mrs S was discharged from Mascalls Park Hospital in December 2005, but Mr S says that the Council did nothing about this. Mr S categorically denies the Social Worker's recollection of the events of 24 April 2006, specifically that he was thinking of leaving his wife.

## Help and support from the Council: our findings

68 Mr S says that the Council did not provide him with the help and assistance he needed. The evidence is that the Council provided what services it could, in the way of the visiting and 'sitting' service. The Council's records are consistent in their expressions of concern, and in recording that Mr S claimed that all was well and that no further help was needed – shortly followed by contact from him saying that caring for his wife was a strain, and asking for unspecified assistance.

69 The allocated Social Worker was concerned about the strain on Mr S of caring for his wife, and Mrs S's Consultant had expressed his concern that residential care would be needed (paragraph 56). But as Mrs S did not want to move to a residential home without her husband, and Mr S did not want her to go against her wishes, it appears to us that there was a limit to what the Council could do without suggesting compulsory detention.

## Help and support from the Council: our conclusion

70 On the basis of all of the available evidence, we conclude that the Council provided a reasonable service for Mrs S prior to her detention under the MHA on 28 April 2006. We do not conclude that there was maladministration in this regard.

## Complaint (b): the reasonableness and legality of Mrs S's compulsory detention under the MHA on 28 April 2006

71 Mr S says that the procedure leading to the compulsory detention of Mrs S under the MHA, overseen by a Council ASW, was illegal. He says that:

- he did not give his consent;
- neither of the two doctors involved was acquainted with his wife as specified in the guidance (paragraph 39); and
- the motive for the detention of his wife was that when social workers had visited earlier in the day, Mrs S had made a racist comment to one of them.

72 Mr S also says that he had been promised that under no circumstances would his wife be readmitted to Mascalls Park Hospital following her previous detention there in December 2005, and that that promise was not kept.

### Key events as recorded by the Council

73 On Friday 28 April 2006 the Council's records show that Mr S contacted it asking if his wife could be taken into care. Two social workers called at his home in response. Mr S was out buying a paper. The carer who was providing the sitting service opened the door, but Mrs S asked the social workers to leave and they complied with this request and waited outside. When Mr S returned they spoke to him outside the flat. He said his wife had wandered about during the night; had left the flat on her own; followed him around constantly; and that he had not had any sleep as a result. She was resolute that she would not agree to any intervention which necessitated her leaving her own home without her husband. By this stage Mr S was also concerned about his own health difficulties. The social workers left saying they would telephone him later that day.

74 The social workers discussed the case with a senior officer who arranged for Mrs S's GP and an ASW to visit the couple that afternoon. Mr S's telephone number was unobtainable when dialled, so one of the social workers who had attended earlier that day went back to the S's home in person where she told Mr S about the proposed visit from the GP and ASW.

75 Prior to that visit, the ASW spoke to the GP and a representative of the Council's Care Team to discuss what provision could be made for Mrs S on an urgent basis, should it be impossible for her to remain in her own home. The ASW was told that the Care Team were not able to assist over the weekend; the Elderly Persons Team said there were no spare places at that time in the care homes they knew of which were equipped to deal with Mrs S's needs. The ASW tried to contact Mrs S's Consultant by telephone but her calls were not returned. She then checked with Marigold Ward at Mascalls Park Hospital to see if they knew Mrs S, but they could not contribute to the information she already had. Mrs S's GP was a *'Section 12'* doctor for the purposes of undertaking assessments under the MHA (paragraph 39). The ASW also asked another Section 12 doctor to attend. She knew him to be experienced in mental health issues and to have a good manner with patients.

76 That afternoon one of the social workers who had visited earlier, the ASW, the GP, and the other Section 12 doctor attended the couple's home. Mr S let them in. While the doctors spoke to Mrs S the ASW spoke to Mr S. She

explained his rights as the *'nearest appropriate relative'*. He indicated that he had contemplated walking out and that he had expressed this view to others. The ASW's assessment states:

> *'Mr S is the NR* [nearest relative] *as defined by the Act.*
>
> *'He said that whilst he had reservations about his wife entering hospital he would agree as he could see she was ill + needed therapeutic support.*
>
> *'Mr S said that he had been under virtual house arrest as his wife did not allow him to speak to others, go out (although he did go out to get shopping etc). He said he was concerned about her growing hostility towards him + confused state of mind + had considered leaving as he could no longer cope.'*

77 The ASW told our Investigator that if Mr S had objected at any stage, she would have halted the process, as in her view to continue in the light of opposition from him would have been abhorrent to her as an accountable professional. The ASW could not recall the alleged racist remarks, attributed to Mrs S, being raised by anyone who had been present during the visit conducted in the afternoon of 28 April 2006.

78 The doctors present said that Mrs S insisted there was nothing wrong with her but they considered that she was confused – she believed it was 1900, and that her parents were alive – and she appeared to have limited insight into her condition. The recommendation of both was that she be admitted to hospital for treatment. The ASW decided that the least restrictive option to keep Mrs S safe was for her compulsory detention. Mrs S was admitted to Marigold Ward in Mascalls Park Hospital under Section 3 of the MHA. The ASW said that this hospital and ward were chosen as the most appropriate local setting where a bed was available. (This was the same ward where she had previously been detained in December 2005 and had had a fall incurring a slight cut to her head.)

## Mr S's recollections and views

79 Mr S says that Mrs S had recently changed GPs and had only seen her new GP once, so he did not know her at all well. He considered that Mrs S's Consultant from the hospital should have been present. He denies having given his consent to his wife's detention under the MHA, or saying he was thinking of leaving her, and says that the doctors who were present had been chosen by the social worker who had been allegedly racially abused by his wife. He suggests that the ASW and social workers have lied and the records are inaccurate.

## Compulsory detention: our findings

80 As has been explained earlier, the actions of the doctors in this case are outside the Health Service Ombudsman's remit. Mr S undoubtedly found the sectioning of his wife distressing. In the light of subsequent events – his wife's fall from bed whilst in Mascalls Park Hospital, which resulted in her breaking her hip, and her subsequent admission to a different hospital for an operation and her death – he understandably sees her detention as the first incident in a chain of events which led to his wife's death.

81 The Council's records, which appear to be genuinely contemporaneous, demonstrate that the proper procedures were followed. The ASW noted that Mr S had given his consent as the *'nearest appropriate relative'* and no one else

present has suggested that he objected. The GP had a previous acquaintance with Mrs S, as required by the MHA. He may have only seen her once, but it would have been reasonable to assume that he would have had access to her medical records, and the MHA does not define *'previous acquaintance'*. It is clear too that the two doctors were selected by the ASW, who had not seen Mrs S before.

82 Our Investigators have looked carefully at all of the available records for any evidence of a previous promise made to Mr S that in no circumstances would his wife be readmitted to Mascalls Park Hospital after her detention there in December 2005. The Consultant's letter of 20 March 2006 (paragraph 63) referred to emergency respite or residential care, but did not say that Mrs S should not be readmitted to Mascalls Park Hospital should an urgent need arise.

83 In June 2006 (while Mrs S was still in hospital) the Consultant wrote to the Council to say that he did not feel Mrs S would benefit from any further admissions to an acute psychiatric setting, as an elderly mentally impaired placement in a residential setting was needed. During the Trust's investigation into Mr S's complaint, the Consultant was contacted about the claim that he had said Mrs S should not be readmitted to Mascalls Park Hospital. The Consultant said merely that there had been several conversations about a decision having to be made about Mrs S's long-term care, but that Mr S was resistant to the notion of residential care as he did not want to upset his wife.

84 There is no record of an undertaking that Mrs S would not be readmitted to Mascalls Park Hospital. Given that Mrs S did not want to go into a residential home (and Mr S supported her in that), in the event that such a placement was to be considered she would first have had to be compulsorily detained for assessment under Section 2 of the MHA. The assessment would then identify the most appropriate setting. The ASW decided that Marigold Ward at Mascalls Park Hospital was the appropriate place for this assessment to be undertaken.

85 Mrs S was non-compliant with her medication, and was detained under Section 3 of the MHA for treatment. When the second Trust were planning for her discharge it was noted that she would need elderly mentally impaired residential care. However, by then she had broken her hip, and was too unwell to be discharged from hospital care.

### Compulsory detention: our conclusion

86 Having studied all of the available evidence we are satisfied that no maladministration occurred in the procedure which was followed leading to Mrs S's detention and her return to Mascalls Park Hospital.

## Complaint (c): the Council's response to Mr S's complaint

87 As part of our investigation we have considered how the Council responded to Mr S's complaint.

88 On 10 July 2007 Mr S first asked the Council for a complaint leaflet. On 13 August 2007 (the first mutually available date) the Customer Care and Complaint Manager met Mr S and his advocate to discuss his complaint. The Manager said that as the Council could only consider events less than 12 months old she would not look at events further back in time than Mrs S's April 2006 sectioning.

89 Mr S's complaints started with his questioning of the decision to section his wife. He complained about comments made by the Social Worker allocated in 2006, which had made Mrs S very anxious. He said he had indicated that he wanted another social worker assigned but this had not happened. He also thought that the allocated Social Worker had vindictively cut back the home care hours from seven to five following the reassessment of their needs.

90 On 17 August 2007 the Manager wrote to Mr S with a summary of the meeting. She asked if he was agreeable to extending the ten-day deadline for a reply by a further ten days, owing to the complaint concerning matters from some time ago. On 28 August Mr S telephoned with some amendments; in particular he said that when he had asked for a meeting with Social Services in the hospital it took six weeks to arrange.

91 On 14 September 2007 the stage one complaint response was sent by the Manager of the Care Management and Review Team. They suggested Mr S contact the NHS about his concerns over the sectioning and the role of the ASW. They said that the Social Worker did not recall any requests not to visit his home, but she did visit Mrs S in hospital as part of the discharge planning process. They pointed out that the care hours had increased after the allocated Social Worker's visit. They apologised that resource constraints meant that they could not allocate a different social worker. The response did not suggest how Mr S should proceed if he was dissatisfied.

92 Mr S contacted the Complaints Manager, who suggested he approach the Health Service Ombudsman. Mr S continued to raise his concerns with the Council. He also complained separately to the Local Government Ombudsman in October 2007.

### The Council's complaint investigation: our findings

93 Given that the responsibility for the ASW's activities was the Council's, it was not appropriate to tell Mr S to take that issue through the NHS complaints procedure. Shortly after Mr S's complaint to the Council he made his complaint to the Local Government Ombudsman about the actions of the ASW. The Council acknowledges that this advice was incorrect, but notes that at the time the ASW was part of a joint team which was believed to be under the management of the Mental Health Trust.

### The Council's complaint investigation: our conclusion

94 The Council was wrong in telling Mr S to take his complaint about the ASW to the Health Service Ombudsman. However, we do not consider that was so serious an error as to amount to maladministration.

## The complaint about the Council: our overall conclusions

95 We find that the way the Council provided services for Mrs S, and the procedure its staff followed in applying for her compulsory detention, did not fall below a reasonable standard in the circumstances. We therefore find no evidence of maladministration by the Council. We have also considered separately the way in which the Council responded to Mr S's complaint, but again find no evidence of maladministration.

96 Mr S says that alternative provision could have been made for his wife before her admission to hospital. But as he had said his wife would not go into residential care voluntarily, and he did not want her to go back to Mascalls Park Hospital to afford him some respite, it appears that there was little in practical terms that could be done at that time. Given Mrs S's needs it seems that supported housing with an on-site warden (if such had been available) would not have resolved these difficulties.

97 Therefore, we do not uphold Mr S's complaint about the Council.

## The Ombudsmen's investigation into Mrs S's care by the Trust

98 The background to this complaint is outlined in paragraphs 52 to 57. We say more about the key events associated with each aspect of the complaint in the sections which follow.

### Complaint (d): the Trust's care for Mrs S at Mascalls Park Hospital

99 Mr S said that the Trust should have been aware his wife had fallen out of bed during her previous stay (paragraph 57). Thus, cot sides should have been used to prevent another fall; he was not contacted until some time after a second fall happened and was given confusing information about its cause.

#### Key events

100 Mrs S was admitted to Marigold Ward in Mascalls Park Hospital on 28 April 2006, under Section 3 of the MHA. The notes of her earlier stay were not located and integrated with those for her new stay, despite Mr S mentioning the relevance of the previous stay. On the evening of 2 May the Hospital's notes record Mrs S as being restless and agitated, and accusing staff of hitting her and taking her possessions. She was given lorazepam at 11.00pm but this had little effect. She was restless throughout the night and required a nurse to sit with her. The Hospital's notes say she eventually settled at 5.00am.

101 On the morning of 3 May 2006, at some time between the observation at 5.00am when it is noted that she had settled and 6.30am, when she was next seen, Mrs S had an unwitnessed fall in her room. At 6.30am she was found by a nursing assistant lying on the floor beside her bed. She complained of pain in her left leg and hip when lifted back into bed.

102 She was seen later by the Duty Doctor (Mrs S was fast asleep in bed at the time) who recommended two-hourly observations of her pulse, blood pressure, and respiratory rate until the review which would later be conducted by the Ward Doctor. While being assisted with her personal care by nursing staff, it was noted that Mrs S was unable to bear weight on one of her legs. She was complaining of pain but declined analgesia. She also vomited. The Duty Doctor was contacted again and advised nursing staff that she would hand over to the Ward Doctor who would be in attendance from 9.00am.

103 Mrs S was later reviewed by the Ward Doctor who contacted an Orthopaedic Senior House Officer (SHO). Mrs S was transferred to the second hospital (managed by a separate Trust) where a fracture of the left hip was diagnosed and operated on, on 5 May 2006.

104 On 30 June 2006 Mrs S sadly died whilst still in the care of the second Trust. The death certificate stated that the cause of death was:

*'I (a) Aspiration Pneumonia*

*(b) Ulcerative Oesophagitis with Oesophageal Stricture*

*II Fracture Left Neck of Femur (operation for) Osteoporosis.'*

## Mr S's recollections and views

105 In his complaint to the Trust Mr S said that when he telephoned the ward at 9.20am on 3 May 2006 he was told that his wife was asleep in bed after having had a fall, which had happened when a carer let go of her while talking to another person. Mr S called back at midday and was told his wife had been taken to the second hospital for an X-ray. He went to A&E at that hospital and asked a staff member there what had happened. He was then told Mrs S had been left for half an hour by a carer who then found her lying on the floor. He says that, later in the day, he was told that she had been found in the bathroom rather than her bedroom.

106 Mr S complained to the Trust that he had been given four different versions of the circumstances surrounding his wife's fall and the location of the incident; that he had not been told about the fall immediately after it had happened; and that he wondered if the staff had been negligent, given Mrs S's previous history of a fall whilst in the same ward and her increased vulnerability as a result of her dementia.

## The Trust's handling of the complaint about the circumstances surrounding the fall

107 The Trust's complaint investigation was conducted by a lead occupational therapist from Havering Primary Care Trust. She drew up an investigation plan, and interviewed relevant staff members as well as, by telephone, Mr S. She obtained both hospitals' case notes, and compiled her own notes dated 6 May 2006. She set out her conclusions in a report dated 14 June 2006 and provided a plan which listed the following recommendations:

- *'To ensure use of Clinical Risk Assessment and Management Programme for Older People.*
- *Communication issues: Concerns raised by relatives should always be recorded in case notes.*
- *Accident/Incident forms should be made available to relatives on request.*
- *Clinical notes: If not available at time of admission – make every effort to trace notes and ensure that all relevant documentation are either integrated into new volume or read and recorded as such.*
- *Communication – Ensure effective communication with relatives. Inform of any changes in respect of transfer to another ward or hospital as soon as possible ....'*

108 The Trust identified staff to implement these actions *'with immediate effect'*.

109 A detailed response to Mr S was provided on each issue of complaint. Some failings in Trust procedures were identified, and an apology

was offered. Details of the actions to be taken to improve procedures in future were also provided. The Trust advised Mr S that he could complain to the Healthcare Commission if he was dissatisfied with their response.

110 Mr S continued to have contact with the Trust after this date and a local resolution meeting was held in May 2007 but he remained dissatisfied. Mr S complained directly to the Health Service Ombudsman on 19 October 2007.

## The Trust's response to our provisional findings

111 The Trust responded on 2 November 2009 commenting that they accepted the findings, conclusions and recommendations of the draft report.

## Responses to our enquiries by the Trust

112 Our Investigator wrote to the Trust on 2 June 2008, asking for the records relating to Mrs S's admission to hospital as well as the Trust's *Falls Management Policy* – both at the time of the incident and currently.

113 On 25 June 2008 the Trust provided Mrs S's clinical records, but these were in respect of her first admission to hospital in December 2005, and not her second in April 2006. The *Falls Management Policy* from December 2007 was sent, but no earlier policy was provided. In August 2008 our Investigator again asked for the relevant documents. The Trust responded, but the Investigator and one of our Professional Advisers found there was still information missing, so both visited the Trust in October 2008 to examine the medical records. The missing papers proved to be with the complaint file.

114 By mistake on the part of the Trust, our Investigator's request for the *Falls Management Policy* was also treated as a *Data Protection Act* Subject Access Request and was responded to thus in September 2008. That response said that there was no earlier policy – a fact that had been omitted when the *Falls Management Policy* had been provided earlier.

## The advice of the Ombudsmen's Professional Advisers

### Falls assessment

115 Our Nursing Adviser noted that at the time of Mrs S's fall on the ward it appears that there was no specific policy related to the prevention and management of in-patient falls (paragraph 114). She did note that falls risk screening was an integral part of the Trust's *Clinical Risk Assessment and Management Policy* (2005 Appendix 4). This signposted staff to a full assessment tool if a person was identified as being at risk following initial screening. It is evident that a falls screening tool was utilised, and falls assessment documentation completed, during Mrs S's previous admission in December 2005, but on 28 April 2006 – the date of her second admission – other assessment documents were completed, but nothing in relation to a falls risk assessment.

116 Thus, the Nursing Adviser noted that, whilst it is evident that there were processes available to assess risk, a falls risk assessment was not undertaken for Mrs S. The concept of assessment is part of the *NSF for Older People*, and a comprehensive general assessment is described as key to establishing the needs of an older person admitted to hospital.

117 Mr S felt that following the admission on 28 April 2006 staff should have been aware of the previous fall in December 2005 and used cot sides on the bed as a preventative measure. During the Trust's investigation this aspect had been discussed with the Ward Manager who said that, owing to the fact that Mrs S was very agitated, it would not have been appropriate to use cot sides, as she could have tried to climb over them which would have been considered both dangerous and a risk. Our Nursing Adviser has confirmed that this is a relevant professional concern, and that it is important to recognise that the use of cot sides is not appropriate for all patients as they may create a greater hazard for some patients, particularly those who are both confused and mobile enough to climb over them. When cot sides are being considered a full risk assessment should thus be undertaken.

118 Linked to that point, our Nursing Adviser said that it would have been good practice (*NSF for Older People*, Standard 6 – paragraph 47): to have carried out an assessment of the risk of Mrs S having a fall and considered the measures to reduce that risk; to have discussed this with Mr S; and thereafter to have developed an appropriate care plan. This would have clearly demonstrated that both a proactive and person-centred approach was being adopted in relation to Mrs S's care: this was of particular significance given the fact that Mrs S had a history of falls, including one on her previous admission. The Nursing Adviser also said that even with an appropriate plan of care and necessary interventions in place, without the resource to provide one-to-one supervision, the risk of some patients falling is likely to be ever-present. Again, however, these facts should have been explained to Mr S.

### The Trust's investigation into the fall

119 The incident report completed by the ward staff after Mrs S's fall gave the *'graded consequence score'* about the incident as *'minor'*. Our Nursing Adviser was critical that the Trust's investigation did not question the accuracy of this score, given the actual consequences. (The Nursing Adviser noted that the Trust's risk assessment documentation indicates that an assessment of risk is based on an event occurring that constitutes a risk to an individual, the environment, or the organisation. It is measured in terms of consequences and likelihood whereby risk = consequences x likelihood. The Nursing Adviser said that the consequence score recorded for Mrs S was incorrect: the consequence of her injury was not minor, but serious, and required medical treatment.)

120 Our Nursing Adviser was concerned that the nurse who completed the form was not aware of the potential seriousness of the injury, later confirmed as a fracture which required surgery. There is no comment in the Trust's investigation report on whether the overall risk score had been calculated – this is important because the level of identified risk is used to assist in determining the level of investigation required.

### Lack of neurological assessment

121 Our Nursing and Medical Advisers also commented on the management and care of Mrs S immediately following her fall. It does not appear from the records in the unified clinical notes that Mrs S had a full clinical examination when reviewed by the Duty Doctor at 7.15am. The entry states:

> *"'ATSP"* [asked to see the patient who] *had a fall and was complaining of pain in her left*

*leg. When seen by the Duty Doctor Mrs S was fast asleep in bed. Blood Pressure (BP) taken was 130/70, pulse 90/min taken by staff. The plan was to observe pulse, BP and respiratory rate (RR), two hourly until reviewed by doctor. To be reviewed by Ward Doctor.'*

122 There is no record of Mrs S's leg being examined for any evidence of a hip fracture by way of shortening of the limb and/or external rotation.

123 Our Nursing Adviser commented that when a person has had an unwitnessed fall it would be appropriate to undertake a neurological assessment to establish if a head injury has been sustained. Our Medical Adviser confirmed that a more robust examination should have been undertaken at the time, because the consequences of a head injury can be serious and a neurological event may in some circumstances precipitate a fall. In Mrs S's case observations were not prescribed beyond basic physical observations of temperature, pulse, and blood pressure. Our Medical Adviser concluded that in such circumstances neurological observations and assessments should have been undertaken. Mrs S was subsequently reviewed by the Ward Doctor at 9.00am and the appropriate referral to an Orthopaedic SHO was made.

### Contacting Mr S

124 Our Nursing Adviser commented that there was a fundamental error of communication with Mr S following his wife's fall. The fall happened at approximately 6.30am on 3 May 2006. Mr S was not informed of this event until he enquired about his wife (the time of his telephone call is not recorded but is thought by the Staff Nurse to have occurred between 8.30am and 9.00am, whilst Mr S recalls the time as 9.20am). The Nursing Adviser has commented that it would be usual on admission to establish full contact details of nearest relatives and to establish whether family members wish to be informed of any untoward events – and if so, whether it would be appropriate to make contact at any time of day or night. These points had not been clarified with Mr S.

125 When Mr S contacted the ward he was informed that his wife had fallen and was resting in bed, waiting to see the doctor, and might be transferred to the second Trust for further investigation. There is no written entry in the notes to indicate that Mr S had been informed of his wife's actual transfer. The Staff Nurse involved acknowledged during the Trust's investigation into the events that Mr S should have been contacted as soon as possible after his wife's fall. Our Nursing Adviser has commented that it is an integral part of good nursing practice (NMC: *The Code: Standards of conduct, performance and ethics for nurses and midwives* 2004) to keep patients and/or their families informed of events such as falls as soon as they occur.

### Record keeping

126 Our Nursing Adviser also commented that in this case there is evidence of poor record keeping: in terms of lack of assessment, care planning, and communication. The quality of record keeping can be a reflection of the standard of professional practice and the NMC has identified record keeping as a fundamental part of care (paragraph 50).[9] Our Nursing Adviser also points out that the Department of

[9] *NMC Standards for records and record keeping 2002*, updated 2005.

Health's Essence of Care (paragraph 48) offers a framework for putting patients and their carers at the heart of the process – a qualitative approach to identifying, measuring and reflecting on the service provided: the Essence of Care's clinical benchmarks on communication and record keeping are useful tools to assist in the auditing of these essential and fundamental areas of practice.

## The Trust's care and treatment: our findings

127 We cannot give a definite answer to Mr S's concern that he was told four different versions of the circumstances surrounding Mrs S's fall. Both the completed incident form and the corresponding entry in the nursing records record that at 6.30am on 3 May 2006 Mrs S had an unwitnessed fall and was found lying on the floor beside her bed. Witness statements provided by staff confirm versions of events as documented on this incident report. We cannot say why other versions of events, including at least one from staff at a different hospital, should have been given to Mr S.

128 No falls risk assessment was undertaken for this second admission of Mrs S; taking account of the clinical advice we have been given, we take the view that that fell significantly short of the accepted standard. However, the Trust's management of Mrs S's care leading up to her fall – in relation to the use of cot sides – seems appropriate. That she fell may have been a consequence of her dementia, rather than poor supervision by the Trust, especially as not long before the fall she was said to be *'settled'*; although, of course, we cannot predict what might have been the consequence in terms of her supervision if an up-to-date risk assessment had been made.

129 Subsequently, the Trust did undertake a reasonable investigation of Mr S's complaint. (Although we note that the Trust's investigation was not conducted by a senior nurse, many of the relevant issues were related to nursing practice.)

130 We note too that, following the investigation, an Action Plan was developed. The actions were reasonable and were clearly intended to be implemented very promptly by the Trust. However, we note that the Plan was not explicitly linked to appropriate Essence of Care benchmarks and, in terms of communication with patients' relations, there was no timescale for implementation of the actions that had been identified.

## The complaint about the Trust: our overall conclusions

131 Having studied all the available evidence, including Mr S's comments, and having taken account of the advice provided by our Professional Advisers, we cannot conclude that there was a clear omission in the management of Mrs S's care immediately prior to the fall, or in the decision not to use cot sides. It is puzzling that Mr S should have been given various different versions of events – it appears to us that there is a single credible version which emerges from the records we have seen: that between observations, Mrs S tried to get up and leave her bed and fell while doing so. We note that there was no detailed examination of Mrs S immediately on her being found, nor an appreciation then of how seriously she might have been injured. However, we have seen that within a relatively short time she did receive an examination by the Ward Doctor. Overall therefore, despite the lack of the initial risk assessment, and of an adequate examination

immediately after the fall, we cannot conclude that the fall could definitely have been prevented or that its potential consequences went uninvestigated for very long.

132 However, having noted the comments of our Professional Advisers, we conclude that there were some clear failings: most importantly, a lack of appropriate assessment before the fall (contrary to the standard set out in the *NSF for Older People*). In addition there was: an inadequate examination immediately after it; a failure to keep Mr S informed; and, in aspects of the record keeping, a failure to follow the standards in the Essence of Care. The Trust also failed to undertake an adequate investigation into the fall. We conclude that in all these respects the actions and omissions of the Trust fell so far short of the applicable standard as to constitute service failure.

## Injustice

133 Mr S's complaint is that poor care and supervision by the Trust led to Mrs S's fall, which precipitated the need for surgery, which in turn preceded her demise. We cannot conclude that, but for an assessment, she would not have fallen – we have learnt that only a few months previously she had had an assessment, yet had still fallen. We have to acknowledge that even after an assessment, and with relatively high levels of supervision, falls among the elderly do still happen – and the use of cot sides can make injury more likely. We also note that Mr S has complained separately about Mrs S's care at the acute trust where she died. However, we conclude that the failure to assess her risk of falling during the second admission to Mascalls Park Hospital meant that there was no opportunity to identify any specific measures to reduce her risk of falling – and so there must be a possibility that she might not then have fallen, and therefore would not have needed surgery. To that extent there was an injustice to Mrs S. In addition, the failure to keep Mr S properly informed of his wife's fall has undoubtedly caused him distress and caused him to be concerned about the overall level of care which his wife received. To the extent that these injustices flow directly from the service failure identified, we **partly uphold** the complaint about the Trust.

## Recommendations

134 The Trust should apologise to Mr S. In relation to the aspect of Mr S's complaint about the failure to keep him informed, we have noted that the Trust's Action Plan, in terms of communication with patients' relatives, had no clear timescale for achievement.

135 In our draft report we recommended the Trust should write to Mr S and to the Health Service Ombudsman to confirm that the planned actions have been implemented. The Trust have confirmed that:

- they now use RiO – the national mental health electronic care record – and this is the primary record for all service users and carers;
- the Policy on *Clinical Risk Assessment* was last updated in June 2009;
- training and assessment in this is now mandatory for the appropriate level of nursing staff;
- carers and relatives are informed when an accident or incident occurs; and

- they will write to Mr S to apologise for the failings identified in the report.

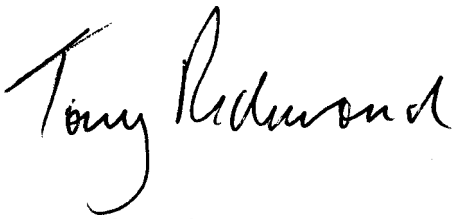
We consider that the Trust's actions are an appropriate response to our findings.

# Section 4: Concluding remarks

136 In this report we have set out the details of our investigation and our findings, conclusions and decision with regard to the care, treatment and service Mr and Mrs S received from the Council and the Trust. We can assure Mr S that his complaints have been thoroughly and impartially investigated and that our conclusions have been drawn from careful consideration of detailed evidence, including Mr S's comments and the advice of our Professional Advisers.

137 We hope this report will provide Mr S with the explanations he seeks and reassure him that lessons have been learnt and learning shared as a result of his complaint, so that others are now less likely to undergo 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 for England**



Tony Redmond
**Local Government Ombudsman**

March 2010

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