Local Government & Social Care OMBUDSMAN

Report by the Local Government and Social Care Ombudsman

Investigation into a complaint against Nottinghamshire County Council (reference number: 19 019 681)

23 June 2021

The Ombudsman's role

For more than 40 years the Ombudsman has independently and impartially investigated complaints. We effectively resolve disputes about councils and other bodies in our jurisdiction by recommending redress which is proportionate, appropriate and reasonable based on all the facts of the complaint. Our service is free of charge.

Each case which comes to the Ombudsman is different and we take the individual needs and circumstances of the person complaining to us into account when we make recommendations to remedy injustice caused by fault.

We have no legal power to force councils to follow our recommendations, but they almost always do. Some of the things we might ask a council to do are:

- apologise
- pay a financial remedy
- improve its procedures so similar problems don't happen again.

Section 30 of the 1974 Local Government Act says that a report should not normally name or identify any person. The people involved in this complaint are referred to by a letter or job role.

Key to names used

Mr C	The complainant
Mrs D	The complainant's mother
X	A family member
Y	A family member
Z	A family friend

Report summary

Adult Social Care

Mr C complained about the standard of care provided to his late mother at a Council commissioned care home, the visiting restrictions imposed on him by the care home, and the Council's safeguarding process which failed to uphold his complaints. Mr C says the Council's failures have caused him personal distress and anxiety and his mother's health deteriorated because of the inadequate care she received.

Finding

Fault found causing injustice and recommendations made.

Recommendations

To remedy the injustice identified in this report we recommend the Council:

- formally acknowledge the failures identified in this report and apologise to Mr C for the frustration, distress, time and trouble the Care Provider's and Council's actions caused him;
- pay Mr C £650 to reflect:
    - the distress he was caused by the Care Provider banning him from the care home without notice;
    - the distress he was caused from not seeing his mother for six weeks; and
    - his time and trouble in having to raise his complaints with both the Care Provider and Council for the restrictions to be removed;
- through contract monitoring processes ensure the Care Provider:
    - reminds care staff about what actions to take before a person is excluded from a care home;
    - reminds care staff about the importance of recording risk assessments and that these are evidence based rather than opinion;
    - provides training to staff about anti discriminatory recording and behaviours;
- remind staff about the importance of telling people the outcome of safeguarding investigations as quickly as possible;
- remind staff about recording and completing any follow up actions arising from a safeguarding investigation.

The Council has accepted our recommendations.

The complaint

1. Mr C complained about services provided at Berry Hill Park Care Home, to his late mother, Mrs D. We have used Mr C and Mrs D rather than real names to protect anonymity.
2. Mr C complained about:
   - the care Mrs D received in Berry Hill Park Care Home;
   - wrongly put in place deprivation of liberty safeguards to prevent him from taking Mrs D out of the care home;
   - the Council's best interest decision Mrs D should remain at Berry Hill Park Care Home; and
   - the Council's safeguarding investigation.
3. Because of these failures Mr C considers the Care Provider neglected Mrs D and she did not receive the care she should have. He also believes he lost time with his mother after the care home inappropriately restricted his access to her. Mr C says the Council's failures caused him distress and frustration.

Legal and administrative background

The Ombudsman's role and powers

4. We investigate complaints about 'maladministration' and 'service failure'. In this report, we have used the word 'fault' to refer to these. We must also consider whether any fault has had an adverse impact on the person making the complaint. We refer to this as 'injustice'. If there has been fault which has caused an injustice, we may suggest a remedy. ***(Local Government Act 1974, sections 26(1) and 26A(1), as amended)***
5. We cannot question whether a council's decision is right or wrong simply because the complainant disagrees with it. We must consider whether there was fault in the way the decision was reached. ***(Local Government Act 1974, section 34(3), as amended)***
6. We investigate complaints about councils and certain other bodies. Where an individual, organisation or private company is providing services on behalf of a council, we can investigate complaints about the actions of these providers. ***(Local Government Act 1974, section 25(7), as amended)***
7. When a council commissions another organisation to provide services on its behalf it remains responsible for those services and for the actions of the organisation providing them. So, if we find fault with the actions/service of the care provider, we make recommendations to the council.
8. We normally name care homes and other providers in our reports. However, we will not do so if we think someone could be identified from the name of the care home or care provider. ***(Local Government Act 1974, section 34H(8), as amended)***
9. We normally expect someone to refer the matter to the Information Commissioner if they have a complaint about data protection. However, we may decide to investigate if we think there are good reasons. ***(Local Government Act 1974, section 24A(6), as amended)***

Relevant law and guidance

The Care Act 2014

10. Section 42 of the Care Act 2014 says a council must make necessary enquiries if it has reason to think a person may be at risk of abuse or neglect and has needs for care and support which mean he or she cannot protect himself or herself. It must also decide whether it or another person or agency should take any action to protect the person from abuse or risk.

The Mental Capacity Act 2005 and Code of Practice to the Mental Capacity Act

11. The Mental Capacity Act 2005 is the framework for acting and deciding for people who lack the mental capacity to make decisions for themselves. The Act (and the Code of Practice 2007) describes the steps a person should take when dealing with someone who may lack capacity to make decisions for themselves.

12. A key principle of the Mental Capacity Act 2005 is that any act done for, or any decision made on behalf of a person who lacks capacity must be in that person's best interests. Section 4 of the Act provides a checklist of steps that decision makers must follow to determine what is in a person's best interests. The decision maker must also consider if there is a less restrictive choice available that can achieve the same outcome.

13. The Deprivation of Liberty Safeguards (DoLS) is an amendment to the Mental Capacity Act 2005 and came into force on 1 April 2009. The safeguards provide legal protection for individuals who lack mental capacity to consent to care or treatment and live in a care home, hospital or supported living accommodation. The DoLS protect people from being deprived of their liberty, unless it is in their best interests and there is no less restrictive alternative. The legislation sets out the procedure to follow to obtain authorisation to deprive an individual of their liberty. Without the authorisation, the deprivation of liberty is unlawful.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

14. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2014 Regulations) set out the requirements for safety and quality in care provision. The Care Quality Commission (CQC) issued guidance in March 2015 on meeting the regulations (the Guidance.). We consider the 2014 Regulations and the Guidance when determining complaints about poor standards of care.

15. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

- Regulation 12 – "Safe care and treatment". Providers must assess the risks to people's health and safety during any care or treatment. Guidance says providers must do what is reasonably practicable to mitigate risks;
- Regulation 13 – "Safeguarding service users from abuse and improper treatment". This regulation says a person should not be deprived of their liberty without lawful authority;
- Regulation 14 – "Meeting nutritional and hydration needs". Providers must ensure people have enough to eat and drink to meet their nutrition and hydration needs and receive the support they need to do so. This is to reduce risks of malnutrition and dehydration.
- Regulation 17 – 'Good governance'. Providers must have systems and procedures to assess, monitor and mitigate any risks relating to the health,

safety and welfare of people using services. Providers must also maintain accurate, complete and detailed records for each person using the service.

16. CQC's "Information on visiting rights in care homes – detailed version" says care home visits for those who lack mental capacity should be enabled unless there are compelling reasons to say the visits are not in their best interests.

Human Rights Act 1998

17. The Care Act 2014 says CQC regulated Care Providers are acting as public authorities for the purposes of the Human Rights Act 1998 (HRA) if a local authority funds/arranges a person's care. This means that if a local authority funds/arranges a person's care then the Care Provider is a public authority and so the person gets the protection of the HRA.

18. The Human Rights Act 1998 brought the rights in the European Convention on Human Rights into UK law. Public bodies, including councils, must act in a way to respect and protect human rights. It is unlawful for a public body to act in a way which is incompatible with a human right. 'Act' includes a failure to act. ***(Human Rights Act 1998, section 6)***

19. It is not our role to decide whether a person's human rights have been breached. That is for the courts. We decide whether there has been fault causing injustice. Where relevant, we consider whether a council has acted in line with legal obligations in section 6 of the Human Rights Act 1998. We may find fault where a council cannot evidence it had regard to a person's human rights or if it cannot justify an interference with a qualified right.

20. Article 5 of the European Convention on Human Rights says everyone has the right not to be deprived of their liberty except in limited cases including the detention of someone who is of "unsound mind".

21. Article 8 of the European Convention on Human Rights says everyone has a right to respect for their private and family life, home, and correspondence. This right is qualified which means it may need to be balanced against other people's rights or those of the wider public. A qualified right can be interfered with only if the interference is designed to pursue a legitimate aim, is a proportionate interference and is necessary. Legitimate aims include:

- the protection of other people's rights;
- national security;
- public safety;
- the prevention of crime;
- the protection of health.

Equality Act 2010

22. The Equality Act 2010 protects the rights of individuals and supports equality of opportunity for all. It offers protection, in employment, education, the provision of goods and services, housing, transport and the carrying out of public functions.

23. The Equality Act makes it unlawful for organisations carrying out public functions to discriminate on any of the nine listed protected characteristics. The Public Sector Equality Duty also sets out duties for such organisations to follow to stop discrimination. The 'protected characteristics' referred to in the Act are:

- age,
- disability,

- gender reassignment,
- marriage and civil partnership,
- pregnancy and maternity,
- race,
- religion or belief,
- sex, and
- sexual orientation.

24. Direct discrimination occurs when a person or service provider treats another less favourably than they treat or would treat others because of a protected characteristic.

How we considered this complaint

25. We spoke with Mr C, considered written information he provided and made enquiries of the Council. We considered:

- the Council's response, and documents provided by both Mr C and the Council. This included safeguarding and case records;
- Care and Support Act 2014;
- Care and Support Statutory guidance (CASS);
- Mental Capacity Act 2005;
- Deprivation of Liberties Safeguards;
- The Equality Act 2010;
- Human Rights Act 1998.

26. Mr C, the Council and Care Provider had an opportunity to comment on our draft report. We considered any comments received before producing the final report.

What we found

Background information

27. Mrs D and Mr C lived together in the community. Mr C has a history of mental health problems. After Mrs D developed dementia Mr C became her main carer. Because of an increase in Mrs D's care needs she moved into Berry Hill Park Care Home, a residential care home run by HC-One Limited, the "Care Provider". The Council arranged and funded the care home. Mr C continued to support his mother visiting daily.

28. Mrs D had a close family member, who we refer to as X. X lived abroad but visited the country once or twice a year. When in England X saw Mrs D regularly, as did another family member, who we refer to as Y. Mr C says Mrs D had fallen out with X and Y and had little contact with them before moving into the care home.

29. There is no dispute that Mr C and X were concerned about Mrs D's welfare. However both had different views on how the Council should meet Mrs D's needs.

What happened

30. In August 2018, the Care Provider made a safeguarding alert to the Council as Mr C threatened to move Mrs D after he found her bruised. Mr C says the Care Provider did not warn him about the bruising, and he only found out when he

visited the care home and saw his mother. The Care Provider told him they forgot to contact him. Mr C says this was not an isolated incident and on at least three further occasions Mrs D had been at risk. Mr C also alerted the Council that Mrs D did not have a DoLS in place.

31. A few days later the Care Provider said Mr C had become loud and aggressive after he saw X visiting Mrs D. The Care Provider said some of the altercation happened in the main lounge in front of other residents, some of whom felt threatened. Mr C had not however aimed any of his anger at the residents or staff.

32. A staff member escorted Mr C out of the care home. Within 20 minutes Mr C had calmed down and apologised to the staff member. Following the incident the Care Provider wrote to Mr C banning him from the care home. The Care Provider did not give Mr C any warning nor did it discuss its concerns before the ban. At the time the Care Provider did not have a specific policy or process in place for visitor restrictions.

33. During the safeguarding investigation the care home raised further concerns about Mr C which included:

- Mr C providing personal care to Mrs D with Z, a family friend;
- Mr C's preference for some carers over others and only wanting those carers to provide care to Mrs D;
- Mr C was verbally "abusive" and threatening to staff members;
- Mrs D was often anxious after Mr C's visit;
- personal comments about Mr C and the way some staff felt around him, that he made them feel uncomfortable, negative comments about his appearance, demeaner and "different" behaviour.

34. Mr C says these were all false allegations.

35. As part of the safeguarding investigation the Council interviewed members of staff, asked for Mr C's views and those of other family members, and reviewed care records.

36. Over the next few weeks Mr C made both safeguarding alerts and complaints to the Council, he also started to look at an alternative care home. The Council dealt with these together. They included:

- Mrs D did not always have access to water;
- Mrs D was often in soiled or wet clothing and left to urinate in public places;
- Mrs D did not receive acceptable personal care;
- the Care Provider was short staffed and could not properly care for residents;
- the Care Provider's inability to manage Mrs D's mobility;
- lack of social stimulation for Mrs D;
- the failure to meet Mrs D's religious needs. Although a priest visited the care home regularly the care home prevented Mr C from taking his mother to church;
- the Care Provider's discrimination against him because of his mental health problems. He says because of this the Care Provider gave more weight to X's views and preferences than his;

- inappropriately shared information with X; and
- contacted Z about an incident without telling Mr C first.

37. After the Care Provider imposed restrictions on Mr C his relationship with staff members worsened. Mr C felt Mrs D should move to a different care home or return home to live with him.

38. Alongside the safeguarding investigation a separate Council department undertook assessments as part of DoLS. The Care Provider had asked for an urgent authorisation as it felt the way in which it provided care to Mrs D could potentially be a deprivation of her liberty.

39. The DoLS assessor interviewed members of staff, considered care records, met with Mrs D, and spoke with Mr C. The assessor also considered the restrictions on Mr C.

40. Both the safeguarding investigating officer and the DoLS assessor criticised the way in which the Care Provider had acted in banning Mr C from the care home. It failed to:

- properly consider Mrs D's right to family life, a potential breach of her Article 8 rights;
- properly record or evidence any of the claims it was making in defence of its actions or the safeguarding alert; and
- engage with Mr C with a view to taking less restrictive action.

It also imposed a ban without any tangible evidence that Mrs D or anyone else, staff member or resident was at risk from Mr C. And appeared to apply a ban to Z, a frequent visitor to Mrs D without any proper cause or reason.

41. The DoLS assessor concluded Mrs D was deprived of her liberty but that it was necessary and the least restrictive option available to maintain her care and safety. By this time, the Care Provider had agreed restricted access between Mr C and Mrs D. It said the first visits would be in public areas and supervised. The DoLS authorised the deprivation but for a shorter period than usual to give the Care Provider an opportunity to resolve matters with Mr C and for the assessor to review the authorisation.

42. The Council completed a best interest assessment. After considering the views of all those involved both family and professionals, it decided that it was in Mrs D's best interest to remain at the care home.

43. The safeguarding investigation into Mr C's allegations about the Care Provider concluded that:

a) another resident had superficially bruised Mrs D while trying to move her away from their personal space;

b) there were times when staff found Mrs D in communal areas wet or soiled. This was mainly due to Mrs D not always cooperating with staff in a toileting schedule, and Mrs D's incontinence which meant she did not always know when she needed to use the toilet;

c) Mrs D would have no access to water when the Care Provider was refilling water jugs;

d) there was weight loss but there was nothing to suggest this was because of poor nutrition but more likely than not because of reduced swelling from an oedema in Mrs D's leg; and

e) the staffing ratio within the care home met government guidelines. There may have been occasions when Mrs D did not receive personal care, but this was generally when the staff were unable to engage with Mrs D rather than out of neglect.

44. The Council recorded (a) to (c) as substantiated concerns.

45. The Council did not uphold Mr C's complaints about the care Mrs D received. It wrote to Mr C on 15 January and 14 February 2019 providing the outcome of the safeguarding and complaint investigation. It said the Care Provider had taken suitable action:

- it had referred Mrs D to both the falls clinic and the incontinence service;
- care staff were now observing Mrs D every 15 minutes;
- the Care Provider had recorded incidents and considered how to prevent reoccurrence and got medical advice when necessary;
- there had been no data breach;
- following a best interest assessment which included gaining views from all those involved; it was not in Mrs D's best interests to attend church. This was because of Mrs D's general frailty and the risk Mr C would not return her to the care home; and
- the Care Provider accepted a staff member had mistakenly contacted Y instead of Mr C and apologised for this.

46. As a result the Care Provider acted to:

- ensure staff replaced water jugs quickly and residents had access to drinks all the time;
- put in place risk assessments to prevent future altercations between Mrs D and other residents; and
- devise a policy about steps care homes should follow if they are considering restricting access to visitors.

47. The Council says the Care Provider supported Mrs D with several activities to provide her with social stimulation and that she engaged with other residents and staff members.

48. By October 2018 the relationship between the Council and Mr C had worsened and Mr C no longer trusted the Council to make unbiased judgements. He felt both the Council and Care Provider sided with X.

49. Mrs D went into hospital in February 2019 and died soon after.

Conclusions

Context

50. This was a complicated case involving difficult family dynamics and many safeguarding allegations and counter allegations. The case records show the Council officers involved were empathetic and impartial. Officers were navigating a difficult family situation while keeping Mrs D at the heart of decision making. The records show officers obtaining the views of all involved, responding to Mr C's frequent emails but also maintaining lines of communication with the care home.

Quality of care at Berry Hill

51. Through its safeguarding investigation the Council identified service failure. Some of the Care Provider's actions were not in line with the regulatory standards, detailed in paragraph 15 above. The Care Provider failed to:

- meet hydration needs by Mrs D not always having easy access to water, (Regulation 14),
- provide safe care and treatment by not addressing Mrs D's incontinence issues, (Regulation 12); and
- protect Mrs D from injury, (Regulations 12 and 17).

52. There is also a lack of record about the activities available to Mrs D and how staff encouraged her to join in these activities. This is fault and not in line with Regulation 17.

53. Mrs D has now died, and we cannot remedy any injustice the Care Provider's actions may have caused her. Mr C has however had time and trouble in raising these issues and anxiety that Mrs D was not receiving the care she should have.

54. There is no fault in the way the Council and the care home decided whether it was in Mrs D's best interests to have church visits. Through the DoLS process the Council obtained views of those involved and made a reasoned decision following the best interest check list. Although Mr C is unhappy with the outcome of the decision, we are unable to criticise decisions where there is no fault in the steps taken in reaching that decision.

55. We do not intend to investigate the alleged data breach as this is a matter for the Information Commissioner.

Restricting Mr C's access to the care home

56. The Care Provider was at fault for failing to properly consider its decision to ban Mr C from the care home. It failed to properly consider whether the ban on Mr C was necessary, the least restrictive, and in Mrs D's best interests. This is not in line with Regulation 13.

57. When the Care Provider lifted restrictions on Mr C's access to Mrs D, it did so conditionally. However there appears to be no risk assessment or rationale about what and how the care home should impose these restrictions. The lack of clear recording and risk assessments are not in line with regulatory standards in particular Regulations 12 and 17.

58. The Care Provider did not consider the impact on Mrs D, or look at ways it could support Mrs D to see her son and limit any potential risk. It did not have a policy that staff could follow and did not give Mr C formal warning before the ban. Both the Council and Care Provider also failed to communicate with Mr C about whether Z could visit. This resulted in neither of them visiting.

59. We consider the Care Provider's restrictions were also not in line with Mrs D's human rights, in particular her right to family life, Article 8. Mrs D was close to Mr C, he visited every day and had lived with her before she went into the care home. The Care Provider's actions interfered with this fundamental right with no clear evidence of how it had reached the decision or attempted to look at ways in which it could avoid the interference.

60. The Equality Act says Care Providers should not discriminate unlawfully against a person with a protected characteristic, this includes mental health problems. The comments made by care home staff about Mr C indicate the Care Provider's

actions were clouded by perceptions they had of Mr C because of his behaviour. This gives cause for concern that Mr C's mental health problems influenced its decision making. The focus was on the irregularity of Mr C's behaviour rather than how anything he did negatively affected Mrs D or others within the care home.

61. The personal comments made about Mr C, and how staff felt around him were opinion and not evidence based. They were criticised by both the DoLS assessor and safeguarding officer. While we understand the Care Provider acted in what it thought was in its, and Mrs D's best interests, the decision making was flawed because of those judgements and not in the spirit of the Equality Act.

62. Mrs D had dementia so continuity and familiarity would have been important. We therefore consider it is more likely than not Mrs D missed Mr C's visits. Mrs D has now died, and we cannot remedy any injustice the Care Provider's actions caused.

63. The Care Provider's actions have however caused Mr C anxiety, distress and frustration which exacerbated his pre-existing mental health problems. Mr C could not visit his mother for approximately six weeks, the Care Provider made the decision without any proper risk assessment, warning or discussion. Mr C lost faith in both the Care Provider and the Council which then impeded his ability to work with them to support his mother.

64. The Care Provider does now have a policy which is in line with good practice and the law. It is unclear whether this was developed because of this complaint, but the proactive steps taken by the Care Provider are welcomed.

Safeguarding

65. The Council followed the Care Act and associated guidance set out at paragraph 10 above. It correctly took safeguarding action when it received alerts initially from the Care Provider and then from Mr C. It investigated the concerns raised and interviewed all relevant parties including Mr C, the care home, family members and other professionals involved. The investigating officer visited Mrs D and considered the use of an advocate.

66. The Council completed a balanced investigation reaching a decision on the allegations made. We are generally unable to criticise a professional judgement unless there is procedural fault. While we understand Mr C is unhappy with the outcome of the investigation about Mrs D's care, we are unable to find fault with the Council's actions.

67. We understand the Council's reasons for combining the safeguarding issues with Mr C's complaints. However we consider this caused some confusion about outstanding care issues and a delay in telling Mr C the outcome of the safeguarding investigation. Even though this was a difficult situation we consider the Council should have told Mr C the outcome of the investigation into him sooner. It should have also set out what follow up actions it intended to take about Mr C's concerns about his mother's care. This would have relieved some of Mr C's anxiety and frustration of having unfounded allegations weighing over him, and reassurance that the Council was listening and taking action about Mrs D's care.

Best interest decisions about Mrs D remaining at the care home

68. It is understandable that Mr C would have lost trust and confidence with the Care Provider, however the focus of the Council was Mrs D. The decision it had to make was whether it was in her best interests to leave the care home, and if it

was, where she should live. We have found no fault in the way the Council completed the best interest assessment. It followed the best interest checklist, considered the views of all those involved, and made a reasoned decision that moving Mrs D would be damaging to her health and wellbeing. There was also no other option available, that could meet Mrs D's needs.

69. Even if there was fault in the decision making process it is unlikely Mrs D would have moved to a different care home. This is because at the time Mr C's choice of care home did not have a vacancy.

Recommendations

70. We consider there was fault by the Council and the Care Provider which caused Mr C and Mrs D injustice. Mrs D has died, and we cannot remedy her injustice. We made recommendations to the Council which it has agreed. The actions are to improve future practice and to recognise the impact the faults had on Mr C.

71. The Council must consider the report and confirm within three months the action it has taken or proposes to take. The Council should consider the report at its full Council, Cabinet or other appropriately delegated committee of elected members and we will require evidence of this. ***(Local Government Act 1974, section 31(2), as amended)***

72. In addition to the requirements set out above, the Council has agreed to:

- formally acknowledge the failures identified in this report and apologise to Mr C for the frustration, distress, time and trouble the Care Provider and Council's actions caused him;
- pay Mr C £650 to reflect:
    - the distress caused by the Care Provider banning him from the care home without notice;
    - the distress of not seeing his mother for six weeks; and
    - his time and trouble in having to raise his complaints with the Care Provider and Council for the restrictions to be removed;
- through contract monitoring processes ensure the Care Provider:
    - reminds care staff about what actions to take before excluding a person from a care home;
    - reminds care staff about the importance of recording risk assessments and that these are evidence based rather than opinion;
    - provides training to staff about anti discriminatory recording and behaviours;
- remind staff about the importance of telling people the outcome of safeguarding investigations as quickly as possible;
- remind staff about recording and completing any follow up actions arising from a safeguarding investigation.

73. Mr C says he will not accept the Council's apology or payment because nothing will remedy the consequences of the Council's actions.

Decision

74. We have found fault by both the Council and the Care Provider acting on behalf of the Council which has caused Mr C and Mrs D injustice. We consider the agreed actions above are suitable to remedy the complaint.

75. As there is a potential breach of the regulatory standards under the information sharing agreement between the Local Government and Social Care Ombudsman and the Care Quality Commission (CQC), we will share this decision with CQC.