Report

on an investigation into complaint no 10 012 561 against Leeds City Council

November 2011

Beverley House 17 Shipton Road York YO30 5FZ

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Table of contents

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.

This report has been produced following the examination of relevant files and documents and interviews with the complainant and relevant employees of the Council.

The complainant and the Council were given a confidential draft of this report and invited to comment. The comments received were taken into account before the report was finalised.

Report summary

Adult Care Services – Residential Care

Ms B was estranged from her family. Shortly before Christmas she learned that her mother was in a care home and not likely to live long. Her brother wrote to the Home saying that Ms B would try to remove their mother from the Home and would upset her by talking about money. The Home passed the information on to Council officers and told Ms B that she could not visit her mother.

A couple of days later an officer asked Ms B's brother about his allegations. He withdrew them but said he was concerned that his mother would be upset by seeing Ms B.

A manager says that the officer concerned was told that Ms B could not be prevented from seeing her mother and that, because of the concern that her mother (Mrs B) might be distressed, staff should assess Mrs B's capacity to decide whether or not to see her daughter.

In the event:

- the Home continued to tell Ms B that she could not visit her mother;
- Ms B had to stand outside the Home and hand a Christmas gift for her mother to staff;
- the officer arranged for a specialist to assess Mrs B's capacity and this took a month.

By the time that the assessment was done and Ms B could visit, her mother had had a stroke and was unable to recognise or communicate with her daughter.

Finding

Maladministration causing injustice

Recommended remedy

The Ombudsman found maladministration in:

- preventing Ms B from seeing her mother between 19 December 2008 and 02 February 2009;
- failing to review the situation after any of the nine contacts from Ms B.

This maladministration deprived Ms B and her mother of the opportunity to speak with each other before they were separated forever by death. The Ombudsman found that the nature and scale of this injustice was difficult to express or quantify.

The Council accepted the Ombudsman's recommendation that it should:

- make a full written apology to Ms B;
- pay for a bench with an inscribed plaque in a location of Ms B’s choice;
- help Ms B to find out where her mother is buried or was cremated;
- pay Ms B £5000 in recognition of the distress caused to her.

There has been comprehensive staff training since the events in Ms B's complaint and so the Ombudsman has not recommended any further action.

Introduction

1. Ms B complains that the Council delayed in responding to her concerns that the staff of a care home had prevented her from visiting her elderly mother (Mrs B) who was a resident. As a result, by the time Ms B was allowed to visit her mother, Mrs B had suffered a stroke and was unable to recognise her daughter. Mrs B died the next day.

The law relating to the Ombudsman

2. The Ombudsman's role is to consider complaints of service failure and maladministration causing injustice. The Ombudsman must consider whether the council has acted reasonably in accordance with the law, its own policies and generally accepted standards. Where a council has acted with maladministration, the Ombudsman considers whether it has caused injustice and can recommend an appropriate remedy.

The law and administrative background relevant to this complaint

3. An underlying principle of the Mental Capacity Act 2005 is that, unless there is reason to doubt it, someone must be presumed to have capacity to make their own decisions. Where it is believed that someone lacks capacity to make a decision, then the person's capacity must be tested against the specific decision which needs to be understood and made: if the person is found to lack capacity to make the decision, then a decision needs to be made in the person's best interests. Part of the information needed to make a decision in someone's best interests includes the knowledge of any wishes they may have expressed previously.

4. An assessment of capacity about a specific decision is usually made by the person who would otherwise have to make the decision on their behalf (so a carer or relative, for example) but where a more complex assessment is required, that can be made by a social worker, doctor, solicitor or other relevant professional.

5. The purpose of the Independent Mental Capacity Advocate (IMCA) service is to help particularly vulnerable people who lack the capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about those decisions.

6. Nationally an increasing number of partnerships between Councils and Health Trusts are delivering integrated social care and health services. In Leeds the Council and the Leeds Community Healthcare Trust (and before it the Leeds Primary Care Trust) work in partnership to deliver social work services to older

people who are recovering from periods of acute poor health, via the Joint Care Management Service. The Joint Care Management Service is made up of workers from different professional backgrounds and includes employees of the Council and the Trust. The service is located within the Trust. Under the partnership arrangement, the responsibility for day to day operational management of the Joint Care Management Service lies with the Trust, but the Council retains overall accountability for the statutory functions of all social care services in the city.

7. In this case, employees of both the Council and the Trust were involved throughout. The Care Manager and Service Manager were employees of the Trust and a senior manager from the Trust provided the formal response to the Council's complaint investigation.

8. Article 8 of the Human Rights Act 1998 offers protection for a person's private and family life from arbitrary interference by the State.

Investigation

9. My investigator has met Ms B to discuss her concerns. She has also examined relevant evidence including the Council's records and interviewed officers who were involved in the events about which Ms B complains.

10. In this report I have not referred to all of the information examined in the course of the investigation but I am satisfied that nothing significant to the complaint or my finding has been omitted.

The events of December 2008 – January 2009

11. Ms B, who works in the field of children's social work, says that she has had a difficult relationship with her parents throughout her life and they have not always been in frequent contact. She says that her brother took over responsibility for their mother's financial affairs when their father died as she herself did not want to do so. She says that there is no history of conflict between herself and her brother despite their infrequent contact with each other.

12. In mid-December 2008 Ms B learned (from another relative) that her mother, whom she had not seen for over two years, was now resident in a care home where she had been placed by an officer of the Joint Care Management Team. When her brother (Mr B) telephoned her the same day, he told her that their mother was nearing the end of her life. Mr B withheld his telephone number so Ms B was unable to contact him subsequently.

13. On 19 December the staff at the Care Home where Mrs B lived contacted the Council's emergency duty team to say that they had received a letter from Mr B (the relative whose details they had as next of kin) saying that Ms B should not

be allowed to visit their mother as she might try to take her from the home and she would upset her by trying to talk about money. The officer who took the phone call advised that Ms B should not be allowed to take Mrs B from the Home, but she did not believe that Ms B could be prevented from seeing her mother. The officer made an electronic record of the call and did not pass any information on to the Council's safeguarding team.

14. Ms B telephoned the Care Home later on 19 December to ask about her mother's welfare but was told that they could not give her any information about her mother, that there had been safeguarding issues raised about her contact with her mother and that she should speak to the Care Manager (who had arranged the placement) if she wanted to know anything further. Ms B says that she spoke to the Home's manager on two more occasions before Christmas and was told that she could not see her mother or come into the home's grounds because of the concerns which had been raised, but that if she wanted to bring a Christmas card or present then she could wait at the entrance and a member of staff would collect it from her.

15. Ms B says that she wanted her mother to know she was thinking of her but did not want to distress her so, very reluctantly indeed, she did as the Home's manager asked and delivered a present to a member of staff at the home's entrance.

16. On 22 December, after the weekend, Ms B spoke to the Care Manager who had been responsible for her mother's placement at the home. She says that the Care Manager said that she would telephone Ms B back and clarify the situation when she had more details: Ms B says that the Care Manager never called her back and that was the only conversation they ever had.

17. Immediately after Christmas 2008, Ms B emailed the Care Manager to follow up her telephone call asking for information. She said that she had no intention of doing anything that would distress her mother and that she genuinely believed that her mother should be allowed to live in peace and free from any conflict which appeared to have arisen between herself and her brother, but of course she wanted to see her mother and know how she was. She also wrote to the Care Home and sent copies to the Care Manager and to an officer in the Safeguarding Adults Unit, whom she also telephoned. The Safeguarding Officer completed an electronic call log when he received her call and, from the record created when the home had telephoned the Emergency Duty Team, noted the type of alleged abuse on the log as 'financial'. The Safeguarding Officer e-mailed a copy of the call log to Ms B on 6 January 2010.

18. On 7 January Ms B complained to the Council and also asked for her brother's role in the matter to be investigated. The Council formally began an investigation of her complaint on 8 January. Ms B was told that an advocate would be

assessing her mother to see whether she was able to make a decision to see her daughter. Ms B wrote again to the service on 12 January to ask about the role of the advocate but did not receive a reply.

19. On 19 January Ms B wrote again to the Care Manager to find out what was happening with her complaint and the progress in arranging for her to see her mother, and asked for a response to her previous emails. She met with officers on 26 January and was told that she could have contact with her mother if she agreed for the contact to be supervised by an advocate or a member of the nursing home staff. She was told that if she did not agree to this, her contact would be 'revoked'. On 2 February the Joint Care Management Team wrote to the Care Home and to Ms B explaining that an advocate had assessed Mrs B as able to make the decision that she wanted to see her daughter, and agreeing an arrangement for Ms B to visit.

20. Ms B says that she was finally able to see her mother on 4 February, but on 3 February Mrs B had suffered a stroke and was unable to recognise or communicate with her. Mrs B died the next day.

21. Ms B specifically asked the Council not to show any of her complaint correspondence to her brother - because of his part in the events. As part of her ongoing complaint Ms B viewed the files about her mother's placement in the Home. She was given an 'open' file which included minutes of meetings between her brother and the officers dealing with the complaint. She was concerned that if her brother had been given the same open access to files he would now have access to personal information about her including her address and contact details. She asked the Joint Care Management Team to clarify this but the response was that she should make it part of her complaint instead.

The Council's response

22. My investigator was not able to interview the Care Manager during this investigation. However, the Service Manager who the Care Manager reported to in her manager's absence gave an account of what happened when Ms B telephoned the Council to say she was being denied access to see her mother.

23. The Service Manager recalls that the Care Home had reported receiving a letter from Mr B (Ms B's brother) saying that he was concerned that his sister would turn up at the home and possibly try to remove her mother, and that at the very least she would distress their mother by wanting to talk to her about money. The Service Manager says she asked the Care Manager to contact Mr B and find out what reason he had for making that statement. She says that the Care Manager reported back (after speaking to Mr B on 23 December) that he had retracted the statement; he said he had no evidence to believe that his sister would try and

take their mother from the home or persuade her to make decisions about her money, but that he was still concerned that her visit after so long would distress their mother.

24. The Service Manager says that even though Mr B had retracted his allegation she felt she could not ignore the matter, which was evidence of a family conflict. She asked the Care Manager about Mrs B's capacity to make the decision about seeing Ms B herself but says that the Care Manager was unsure of Mrs B's capacity and did not feel able personally to assess it. The Service Manager asked the Care Manager to make an urgent referral for an advocate to carry out the assessment of Mrs B's capacity and asked her to tell Mr B that it was not a safeguarding matter.

25. The Service Manager says she also asked the Care Manager to contact Ms B straight away and tell her that they were not in a position to tell her that she could not see her mother; to inform her that the Joint Care Management Team was arranging for an advocate to ascertain whether Mrs B had capacity to make the decision or whether a decision would have to be made in Mrs B's best interests, but that they couldn't say in the meantime that she could not visit her mother. She says she also told the Care Manager to let the Care Home know that they had no reason to stop Ms B seeing her mother. The Service Manager says that although she believes the Care Manager told her that she had telephoned the Care Home, there is no record of the call and she now has no confidence that her advice to have those telephone conversations – to the Care Home or to Ms B – was ever followed.

26. In January 2009 when the Social Work Team Manager (the Care Manager's line manager) returned to work, the Service Manager asked him to let her know what the progress was with the advocate seeing Mrs B. She says that at that point it became clear that the Care Manager had specifically asked for an Independent Mental Capacity Advocate (IMCA) to visit Mrs B despite being asked to refer the matter to a general advocate – the Service Manager says that there was several weeks' delay at that time in being able to arrange for an IMCA and so it was the end of January before the assessment visit could take place.

27. The Service Manager says that with hindsight, although there was no deliberate intention to cause any delay, officers lost sight of the focus of the matter which was Mrs B's right to see her daughter. She also acknowledges that the Joint Care Management Service failed to tell Ms B that it could not prevent her from visiting her mother.

28. The Safeguarding Officer says that there was an unfortunate error in the way the log of Ms B's call was made. He says however that the log was properly completed on the basis of the call which had been made by the home to the duty

team and it was sent to Ms B in an effort to make all possible information available to her.

The Complaint Investigation

29. The Council appointed an independent officer to investigate Ms B's complaint who reported on 12 April 2010. Ms B had complained that staff did not return her calls or respond to her letters; that no-one had ascertained her views before her mother was placed in the Care Home; that the Joint Care Management Service had failed to challenge Mr B's and the Care Home's decision to deny her access to see her mother; that there was a delay in being told what the allegations against her were and what the outcome was; that the Joint Care Management Service had failed to respond to her request that her brother be investigated; that an advocate was used inappropriately, and that confidentiality had been breached.

30. An independent investigating officer (IO) upheld all but one part of Ms B's complaints. The part that the IO did not uphold was Ms B's complaint that the Joint Care Management Service had failed to challenge the Care Home's decision to deny her access to see her mother. He said *"The effect of the decision to go through a best interests process to assist (*Mrs B*) to come to a decision was to freeze any further decision making....It was inevitable that the freezing of the decision making prevented (*Ms B*) from seeing her mother until the best interests process had been completed*.'

31. A senior manager who was responsible for the service provided by the Care Manager wrote to Ms B on 23 July 2010 apologising for the way in which the service had failed. She said that once it had been established that Ms B was not a risk to her mother, the Care Manager was required to establish whether Mrs B wanted to see her. She apologised that this was not properly explained to Ms B and there was also an unacceptable delay in finding an advocate – she added that staff uncertainty about the advocacy process (which had recently been introduced) led to a delay in the process.

32. Ms B met a senior manager after receiving this letter but says that she still was unable to provide all the answers which Ms B sought as to why the Care Manager had failed to respond to all her contacts.

33. Ms B says she knows the originator of the allegations was her brother but because of her own work, she recognised the importance of any allegations being made about her and she was especially concerned that these should be resolved quickly because of the professional implications. For that reason also, she says, she felt she had to "work within the process" and comply with the requests which were made of her by the Care Home staff and the Joint Care Management Service, even when she felt humiliated by the expectation that she had to be supervised when visiting her mother. She also says that as a result of

the failure to keep her details confidential, she felt compelled to change her contact details.

Findings

34. Relatives and friends have the right to visit and see each other without undue interference and the right to respect for family life is enshrined in law. Ms B was told unexpectedly – and without there being any evidence – that she was regarded as a threat to her own mother, denied access to her, made to hand over a Christmas gift outside the Home and made to wait for over a month for the Council's processes before finally being told that she could see her mother. By then her mother was unable to recognise or communicate with her daughter.

35. Two days before Christmas, officers of the Joint Service knew that Ms B's brother had withdrawn his allegation that she was a risk to their mother. From then there were no grounds for preventing mother and daughter from seeing each other.

36. Knowing that Mrs B was dying, officers of the Joint Service arranged a specialist assessment of whether she had the capacity to decide whether she wanted to see her daughter. During the month that it took for this assessment to be done, Mrs and Ms B were prevented from seeing each other – although there was no legal power to stop Ms B from visiting her mother. The Investigating Officer was wrong to say that the effect of requesting the assessment was to 'freeze any further decision-making'.

37. It was maladministration to

- prevent Ms B from visiting her mother from 19 December 2008 to 02 February 2009 and to tell her on 26 January that she could visit if supervised, and
- fail to review the action taken by the Care Manager and the Home after any of Ms B's nine contacts between 19 December and 26 January.

It is no mitigation to say that the delay in arranging to assess Mrs B was because the Mental Capacity Act was new – there was no need for a 'specialist' assessment and the Service Manager says she said so at the time.

38. The maladministration deprived Ms B of the opportunity to speak with her mother before they were separated forever by death. The nature and scale of this injustice is difficult to express or quantify. Ms B can never be put back in the position she would have been in but for the maladministration.

39. The Council has accepted my recommendation, made after consulting Ms B, that it should:

- make a full written apology to Ms B;
- pay for a bench with an inscribed plaque in a location of Ms B's choice;
- help Ms B to find out where her mother is buried or was cremated;

pay Ms B £5000 in recognition of the distress caused to her.

I have not made any recommendation about staff training because the Joint Service has already undertaken sufficiently comprehensive staff training on the issues of capacity since these events took place.

Comment

40. The combined internal complaints process for the Joint Service worked well and the Council and the Trust accepted the findings, implemented the recommendations and made sincere apologies for the failings that had been identified. The Council and the Trust also responded positively to the draft of this Report and demonstrated an impressive commitment to joint working and shared responsibility.

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November 2011