Local Government & Social Care OMBUDSMAN

Report by the Local Government and Social Care Ombudsman

Investigation into a complaint against Wirral Metropolitan Borough Council (reference number: 17 020 182)

28 March 2019

The Ombudsman's role

For 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 X	The complainant, and Mr Y's son
Mr Y	His father
Mr Z	Mr Y's other son

Report summary

Adult social care (home care)

Mr X complains that the Council provided his late father, Mr Y, with a home care service which was not adequate, and charged him for a service he did not receive. When he complained, he says the Council failed to deal with his complaints properly or take effective safeguarding action.

Finding

Fault found causing injustice and recommendations made.

Recommendations

To remedy the injustice caused, we recommend the Council:

- apologise to Mr X detailing the faults identified and the action it has taken, or will take, to avoid similar faults in future;
- waive 50% of Mr Y's care fees to remedy the financial loss it caused;
- pay Mr X £200 to remedy the frustration and stress it caused him;
- refer this case to the local safeguarding board for review;
- ensure all relevant complaints and assessment staff receive appropriate safeguarding training to ensure safeguarding issues are dealt with promptly and appropriately; and
- review the complaint handling in this case and develop an action plan to ensure an improved service in future.

The complaint

1. The complainant, whom I shall refer to as Mr X, complains that the Council provided his late father, Mr Y, with a home care service which was not adequate. He says it:

   - provided fewer hours than it was contracted to deliver;
   - kept inadequate records;
   - issued inaccurate bills;
   - failed to carry out effective safeguarding investigations; and
   - handled his complaints about these issues poorly.

2. Mr X says he spent a lot of time trying to get the right care for Mr Y. The problems caused Mr Y disappointment and distress because of the shortfalls. He could not raise the issues with the Council himself.

3. Mr X also says he does not have a problem with paying for care which was properly provided and invoiced. He does not agree that Mr Y should pay for care he did not receive or which was not properly invoiced.

Legal and administrative background

The Ombudsman's role

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 investigate late complaints unless we decide there are good reasons. Late complaints are when someone takes more than 12 months to complain to us about something a council has done. ***(Local Government Act 1974, sections 26B and 34D, as amended).***

   In this case, Mr X first raised some of the issues in 2016 and formally complained to the Council in January 2017. The Council provided Mr X with its final response in March 2018 and he then came to us. For this reason, we have exercised discretion to consider the issues back to 2016.

6. We may investigate a complaint on behalf of someone who has died or who cannot authorise someone to act for them. The complaint may be made by:

   - their personal representative (if they have one), or
   - someone we consider to be suitable.

   (Local Government Act 1974, section 26A(2), as amended)

7. In this case, we decided Mr X was a suitable person to complain on Mr Y's behalf.

Safeguarding

8. 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. ***(section 42, Care Act 2014)***

9. The Wirral Multi Agency Adult Safeguarding Procedure says:
   - "A principle of no delay applies to all safeguarding adults work" (p23).
   - "Ideally an investigation should be concluded within 28 days" (p23).
   - "The most important element in determining when a safeguarding enquiry can be concluded will be whether the individual is as safe as they can be and that risk has been appropriately identified and mitigating actions taken where possible" (pp23/24).
   - "The initial enquiries will begin on the day of receipt of referral, to ascertain whether the criterion is met, and to check the immediate safety of the adult has been ensured" (p24).

How we considered this complaint

10. We produced this report after examining relevant documents and interviewing the complainant and relevant employees of the Council.

11. We gave the complainant and the Council a confidential draft of this report and invited their comments. The comments received were taken into account before the report was finalised.

What we found

What happened

12. Mr Y had health conditions and disabilities which caused him significant difficulty with mobility and completing daily living tasks. He lived on the ground floor of his home because he was not able to safely use the first floor. Another son, Mr Z, lived on the first floor with his partner. They helped Mr Y with household tasks, although they found this difficult because of Mr Z's own health issues.

13. The Council arranged a package of care and support at home for Mr Y, for which he paid the full cost. The Council paid the care provider, and invoiced Mr Y. By the time of these events, the package consisted of four calls each day with two carers at each call as carers had to hoist Mr Y for all transfers. The support included help with personal care, meal preparation and medication.

14. Mr X lived over 200 miles away and had a third party mandate to access Mr Y's bank account.

15. In July 2016, the Council wrote to Mr Y about outstanding invoices.

16. In August, Mr X emailed the Council because he had found invoices at Mr Y's home and needed more detail before he could arrange payment. He asked the Council to send him copies of invoices by email in future so that he could pay them. He said it was difficult for Mr Y to deal with in his current state of health.

17. The Council completed a review of Mr Y's care package to ensure it was meeting his needs. The review identified that carers had not been using his hoist and sling for transfers and the assessor had concerns that the methods they used were not safe. An occupational therapist (OT) visited with the assessor a few days later and agreed with this view. The OT updated the records in Mr Y 's home and advised the Care Provider that two carers should use the hoist and sling for all transfers.

18. The Council asked the Care Provider about the time it spent on the morning call. The Care Provider advised it had been asked to provide a 45 minute call when it took over, and two carers had always completed the tasks within that time.

19. In early autumn Mr Y's care provider changed.

20. The chronology of the assessment documentation is difficult to follow but it appears the Council carried out an assessment in September. It notes that Mr X would support Mr Y with finances if required, but he didn't hold powers of attorney.

21. In November, Mr X emailed the Council and copied in the Care Provider because he still had not received a response to his August email.

22. In January 2017, Mr X wrote to the Assistant Director Health and Care Outcomes, thanking him for responding to a message he had left. Mr X said he had not received any response to either his August email, or his November email. He said again that he needed to see invoices to make payment. Also, that he was happy to pay "any relevant, appropriate and justified bills for care services" but did need to see what had been provided. He said Mr Y was "disabled, depressed and not in a fit state to deal with the Council about payment of services". He said Mr Y's funds would not last long with care bills of £1,500 per calendar month and asked whether the Council could provide any support. He also listed five issues which had arisen with the Care Provider since it had taken over the care package.

    - Mr Y's eye drops not administered.
    - Mr Y not strapped into his wheelchair creating a fall risk.
    - Carers not washing up after meals and dirty dishes left in the sink.
    - Carer kicking soiled bedding into the kitchen and used pads/underwear left in open bins in the kitchen.
    - Carers putting heavily soiled clothes in the washing machine without soaking.

23. The Assistant Director responded five days later. He said he had passed the complaint on and put a hold on any automatic letters chasing unpaid invoices while the complaint was investigated.

24. On 19 January 2017, the Council wrote to Mr X confirming who would investigate. The deadline for completion was 28 February.

25. On 27 February, one of the Council's internal emails shows the complaint had not yet been considered. A manager decided some of the issues should have been addressed through safeguarding procedures. The officer dealing with his complaint wrote to Mr X to advise it would not be able to complete the investigation by 28 February but expected to respond by 7 March.

26. On 1 March, the Council began the safeguarding process.

27. On 15 March, a Council officer visited Mr Y who confirmed the complaints and raised some new issues. He said the hoist had fallen over with him in it two days previously, and there had been problems with his medication. Mr Y said he was not hurt. The officer found no record of the incident with the hoist but found evidence of discrepancies with medication which had caused an increased risk of seizures. She reported these additional safeguarding concerns. Further enquiries revealed discrepancies with the carers' completion of the communication log and medication not administered although signed for. The carers denied the incident

with the hoist. The officer advised that laundry was not part of the care package and carers had been doing this in their "spare time".

28. On 17 March 2017, the officer met with the Care Provider. When the Council investigated Mr X's complaint, it did not find any notes from the meeting and the officer could not recall what specific issues they discussed. The Care Provider believed they had focussed on concerns about the hoist and medication.

29. On 28 March, the officer met with Mr Z. He felt heavily soiled laundry should be soaked before putting in the washing machine. The officer said she was waiting for feedback on this from the Care Provider. When the Council investigated Mr X's complaint, it did not find any further contact on this matter which remained unaddressed. The Council closed the original safeguarding case about the five issues raised in Mr X's original complaint letter of January.

30. In April, Council records note that visit duration had not improved. It chased the Care Provider who interviewed carer A, one of the regular carers. Carer A had signed for medication he had not given and was on duty when Mr Y said he had fallen in the hoist. Carer A denied the fall from the hoist. He said he could not have picked Mr Y up if he had fallen and said Mr Y made stories up.

31. On 19 April, the Council wrote to Mr X to advise that some of the issues he had raised were being addressed under safeguarding procedures. It said it would need more time to address the invoice issues.

32. In May, Mr X wrote to the Council stating he had not heard from the Council since February. He said Mr Y was still receiving letters threatening recovery by the Head of Legal Services if payment was not made within seven days. Fortunately, these had been intercepted by Mr Z as Mr Y was in hospital again. Mr X asked the Council to stop sending threatening letters, to communicate with him by email and treat him as Mr Y's representative.

33. The Council wrote back and said although it had put a hold on recovery action, it had a duty to send invoices so people are aware of the financial situation. It said it would not send reminders but would continue to send invoices to Mr Y. It also said it does not have a record that Mr Y lacked capacity to deal with his finances and no record of a power of attorney, so wanted a letter of authority from Mr Y. Mr X replied saying he was content for the bill to go to Mr Y as long as he would not be sent threatening letters, and that he would receive a copy by email.

34. In June 2017, a district nurse visited Mr Y at home and found he was in his wheelchair without the lap belt and at risk of falling out. Also, the hoist sling was upside down. She called an auxiliary nurse and the Care Provider. When the auxiliary nurse arrived, the nurses made Mr Y safe. The carers who arrived said they had not been trained in hoisting.

35. A social worker visited Mr Y with a district nurse. Mr Y said carer A had been put out because Mr Y told him about moving the bed quickly and disconnecting the lifeline alert. Mr Z also reported that carer A and carer B, who usually attended with carer A, had been unpleasant about the house and family. Professionals met to discuss the issues and agreed that carers A and B should no longer support Mr Y.

36. In March 2018, the Council sent its final response to Mr X's complaint.

In relation to the standard of care issues it found:

- significant delay sharing the issues with the social work team, identifying safeguarding issues and beginning the safeguarding process; and

- it had failed to properly consider the safeguarding concerns, and had not considered some issues at all. It apologised for this.

In relation to the care charges and short visits it found:

- 59% of calls provided less than 75% of the time commissioned;
- a shortfall of 579 hours 19 minutes; and
- a small proportion of calls exceeded the commissioned time; it gave no information about how much extra.

  The Council said "the focus is very much on completing the tasks required to meet the need. If that means the calls take longer than the scheduled time or less, that is acceptable". It pays for care in 15 minute blocks so would round up a call to the nearest 15 minutes. It says the amount charged has been calculated correctly.

In relation to the delays and poor complaint handling it found:

- it did not respond to Mr X's complaint within the set timescales;
- the response letter contained incorrect information including the date; and
- it had found a clear failing in the service.

It apologised that the complaint had not been managed in an acceptable way and enclosed a cheque for £200 as a gesture of goodwill. It advised that Mr Y's outstanding balance exceeded £26,000.

37. The Council said, in response to our draft report, that Mr Y cancelled or cut short many calls but the Care Provider has not recorded this information. It also says the Care Provider took on a lot of additional work for the Council at a time of great pressure and this affected its recording.

Conclusions

38. The Council has acknowledged several faults in its response to Mr X's complaint. Some of these faults were serious, particularly around the way it dealt with the complaint which contained safeguarding issues.

39. We are concerned that these safeguarding issues firstly went unnoticed, then having been delayed for over one month, were not investigated adequately. The safeguarding enquiry was closed without being completed; this is unacceptable. We know from later incidents that carers continued to put Mr Y at a greater risk of harm than he was already. When the Council did follow up on the issues, it asked the Care Provider to interview staff and took its word about Mr Y's allegation that the hoist fell over with him in it. We found the Council was at fault here in the way it dealt with the safeguarding which was contrary to its own procedure.

40. The Council said it was acceptable for care calls to be shorter than commissioned if the person's needs are met safely, but Mr Y's needs were not being met safely. Carers moved the bed too quickly and disconnected the lifeline alert, were not trained in hoisting and did not strap Mr Y in his wheelchair. They also did not complete records adequately and signed for medication they did not give, putting Mr Y at an increased risk of seizures. These are all serious concerns which put Mr Y at a significant and avoidable risk of harm over at least 18 months. Unfortunately, we cannot now put this right for Mr Y as he has since died.

41. The Council's intention to focus on meeting needs rather than timed tasks is not an issue in itself; to some degree support should be flexible. However, the

Council commissioned support based on the time it believed it should take to meet Mr Y's needs. With 59% of calls providing less than 75% of the time commissioned, it either commissioned far too much time, or the support fell far short of that planned. Whether Mr Y paid the full cost of his care, or a contribution, he should not pay for support he did not receive. The Council has provided some reasons why recording was deficient but we cannot say Mr Y should pay for a service which records suggest he did not receive. The Council was at fault here, and caused Mr Y a significant financial loss.

42. The Council was also at fault in the way it dealt with Mr X's complaint. Had the Council dealt properly with Mr X's complaint, it should have picked up on these other problems sooner and acted to protect him. The repeated delays and lack of response to Mr X's communication, caused Mr X significant and avoidable frustration and stress. Mr Y had told the Council that Mr X would support him with finances if required during his assessment in September 2016. Although there was no legal authority for Mr X to act on his behalf beyond his bank account, the Council does not appear to have had concerns about Mr X's intentions. If it did, it should have taken protective action. Under these circumstances, it could have been more pragmatic about this. Mr X clearly obtained invoices when he visited and it was in Mr Y's interests for Mr X to pay his care bills rather than risk legal action. The Council did not need to treat Mr X as a legal representative; this would be wrong. It just needed to provide Mr X, whom Mr Y had authorised to use his bank account, with copies of the invoices. We found the Council was at fault here and caused Mr X significant and avoidable frustration and stress.

Recommendations

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

- apologise to Mr X detailing the faults identified above and the action it has taken, or will take, to avoid similar faults in future;
- waive 50% of Mr Y's care fees to remedy the financial loss it caused;
- pay Mr X £200 to remedy the frustration and stress it caused him;
- refer this case to the local safeguarding board for review;
- ensure all relevant complaints and assessment staff receive appropriate safeguarding training to ensure safeguarding issues are dealt with promptly and appropriately; and
- review the complaint handling in this case and develop an action plan to ensure an improved service in future.

44. 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)***

Decision

45. We have completed our investigation into this complaint. There was fault by the Council which caused injustice to Mr Y and Mr X. The Council should take the action identified in paragraphs 43 to 44 to remedy that injustice