

**Report by the Local Government and Social Care  
Ombudsman**

**Investigation into a complaint against  
Blackpool Borough Council  
(reference number: 17004032)**

**13 December 2018**

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## 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

Ms X - the complainant

Ms Y - Ms X's mother

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## **Report summary**

### **Adult Social Care – safeguarding**

Ms X complains carers placed her mother Ms Y on a commode next to a radiator causing burns to her legs. She also complains about a delay in completing a safeguarding investigation and about the outcome.

### **Finding**

Fault found causing injustice and recommendations made.

### **Recommendations**

To remedy the injustice, we recommend the Council:

- apologises to Ms Y and Ms X in writing;
- pays £,5000 to Ms Y and £500 to Ms X;
- ensures risk assessments completed by care agencies acting on its behalf identify obvious environmental hazards and care plans are put in place to minimise risks; and
- conducts regular quality assurance checks with the Agency to satisfy itself the Agency is implementing effective risk assessments to ensure clients are safe.

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## **The complaint**

1. Ms X complains about carers from an agency, ICare (the Agency) commissioned by Blackpool Borough Council (the Council).
2. Ms X says carers placed her mother Ms Y on a commode next to a radiator causing burns to her legs. She also complains about a delay in completing a safeguarding investigation and about the outcome. She wants a review of the Council's safeguarding investigation to ascertain why the burns were not dealt with more quickly and a financial payment to reflect avoidable costs of Ms Y entering residential care.

## **The Ombudsman's role and powers**

3. The law says we cannot normally investigate a complaint when someone could take the matter to court. However, we may decide to investigate if we consider it would be unreasonable to expect the person to go to court. (*Local Government Act 1974, section 26(6)(c), as amended*)
4. Ms X could have sued the Council and/or the Agency for negligence. We have decided to investigate the complaint because it is not reasonable for her to go to court because a court would not provide a remedy for one of Ms X's desired outcomes, namely '*to look into the incident in more detail to ascertain why the burns were not dealt with as a matter of urgency... and review the response and timescale of the safeguarding investigation*'.
5. 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*)
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. The Council commissioned and arranged Ms Y's care under its duties under the Care Act 2014 to meet her eligible needs. Any fault in the Agency's service to Ms Y is fault by the Council.

## **How we considered this complaint**

8. We produced this report after examining relevant documents and discussing the complaint with Ms X. We gave the complainant, the Council and the Agency 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**

### **Relevant law and guidance**

9. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2014 Regulations) set out the requirements for safety and quality in care. The

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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.

10. Regulation 12 of the 2014 Regulations says care must be provided in a safe way including assessing risks to the safety of people using the service and doing all that is reasonably practicable to mitigate risks. This includes working with health professionals to ensure the health and welfare of service users.
11. Regulation 20 of the 2014 Regulations (the duty of candour) requires a care provider to be open and transparent when things have gone wrong. As soon as the care provider becomes aware of a safety incident, it must tell the person or their relative; provide reasonable support, advise them of any further enquiries, keep a written record and apologise.
12. If a council has reasonable cause to suspect abuse of an adult who needs care and support, it must make whatever enquiries it thinks necessary to decide whether any action should be taken to protect the adult. (*Care Act 2014, section 42*)
13. The aims of adult safeguarding are to:
  - prevent harm and reduce the risk of abuse or neglect to adults with care and support needs;
  - stop abuse or neglect wherever possible;
  - safeguard adults in a way that supports them in making choices and having control about how they want to live;
  - promote an approach that concentrates on improving life for the adults concerned;
  - raise public awareness so that communities as a whole, as well as professionals, play their part in preventing, identifying and responding to abuse and neglect;
  - provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult; and
  - address what has caused the abuse or neglect.

*(Care and Support Statutory Guidance, 14.11)*

### **What happened**

14. Ms Y received council funded care at home, which the Agency delivered. She has little feeling or movement down the right side of her body after a stroke in 2016. Ms Y had a long recovery in hospital and in rehabilitation to get to the point where she was able to return home. She could walk between rooms with a walking frame.
15. We summarise the Agency's care plan for Ms Y below.
  - She could communicate. Her speech had been affected by a stroke and she knew what she wanted to say but sometimes struggled to get the words out.
  - She could get mixed up due to dysphasia (a language disorder which occurs where the areas of the brain responsible for turning thoughts into spoken language are damaged and do not work properly).
  - Her walking was slow and unsteady. She had right sided weakness due to a stroke. She required two carers for transfers (changing position) with a turner

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- and she used a wheeled commode. She could walk with a frame for short distances, with the carer following behind with the commode for safety.
- She needed full help with personal care and dressing, prompts to take her medication and a soft diet. Carers prepared and served her meals.
  - There were no pressure areas or pressure sores noted.
16. The Agency completed a home risk assessment for Ms Y's home. Its purpose was to identify common household hazards. The risk assessment described the type of heating in Ms Y's home but did not refer to the bathroom or identify any concerns about the position of the radiators. The Council says the risk assessment should have referred to and considered the limited space in the bathroom.
  17. The Agency did not identify any lack of feeling on Ms Y's right side or any implications of this.
  18. Ms Y's morning routine consisted of two carers helping her out of bed, washing her, helping her to dress and use the commode (or walk to the toilet using the walking frame if she was not too tired). The Agency's moving and handling assessment said Ms Y needed two carers to assist her on and off the commode/toilet.
  19. Ms X provided us with copies of the daily records the Agency's carers made in a book left in her mother's home. Key entries are set out in the following four paragraphs.
  20. Ms Y was attended by two carers on 20 October 2017. The Agency's case record at 08:00 to 09:00 noted *'Ms Y fine assisted to wash and dress assisted into lounge prepared cup of tea, meds prompted. Pain in Ms Y's arm on standing. Noticed the red weals on upper thigh. DN [district nurse] to be informed'*.
  21. The following entry is timed earlier at 07.53 and is by an assessments manager who recorded she *'called to carry out a 4-month review had to stay longer as client in pain and distressed'*. The assessments manager then noted at 09:30 that she called back to check on Ms Y because she was still in pain and distressed. Ms Y's social worker and the district nurse were to be informed.
  22. A manager from the Agency phoned the Council's adult social care team at 11.23 saying Ms Y had nine red marks on her leg and carers were reporting she was screaming in pain. A social care officer advised the manager to call paramedics if urgent or call 111 for advice and inform district nurses.
  23. At 11.30, the Agency's records suggest Ms Y was still complaining of pain in her hand and they could not give her pain relief. One of the carers rang an ambulance and contacted a relative (Ms X's brother-in-law). Ms X told us that during the call to her brother-in-law, the carer said her mother's right hand had slipped off the frame that morning and she had been in pain ever since. Ms X told us there was no mention of red weals during the call.
  24. The district nurse came to see Ms Y, noting an ambulance had been called by the carers as Ms Y had fallen earlier. The district nurse's note made no mention of the red weals. She noted Ms Y was sitting in a chair showing signs of distress and carers could not get her to stand due to severe pain and so she could not check pressure areas. The ambulance arrived after about five minutes and the district nurse left Ms Y in the care of paramedics.

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25. Ms X arrived at her mother's home while the paramedics were present. She describes her mother as very distressed, sitting in her recliner chair in the lounge and she had been incontinent. Ms X told us there was no mention of red marks on the leg and her mother was fully dressed. The paramedics gave pain relief and were about to leave; the carers then took Ms Y to change her and one said '*you had better come and look at this*'.
26. Ms X told us her mother's thigh looked similar to the photo below which she took later on the day of the incident.



27. The report by the paramedics said:
- carers said they were mobilising Ms Y into the bathroom and her wrist slipped from the frame. There was no deformity and no obvious injury;
  - they (paramedics) gave pain relief;
  - district nurses were on the scene to assess pressure sores but they were now leaving as there were no pressure sores present; and
  - the crew transported Ms Y to Accident and Emergency as they had now discovered burns on her leg.
28. Ms Y's burns were treated in hospital and she was discharged home the same day. She received regular follow-up visits from district nurses and from the tissue viability service to monitor and dress her leg. The tissue viability nurse reviewed Ms Y's leg on 30 November. The tissue viability nurse's records noted linear burns to Ms Y's right hip ranging between 7 and 12.5 centimetres in length and 1 to 2 centimetres in width. The tissue viability nurse noted the wounds were red and inflamed and Ms Y complained of intermittent pain and had pain relief from her GP for this. The records indicated the wounds became infected and the tissue viability nurse contacted the GP for urgent antibiotics. Ms X told us the wounds

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- became septic requiring a hospital admission for specialist treatment. Ms Y was no longer mobile after the hospital admission and moved into a care home.
29. The Council received a referral from the hospital about the incident and opened a safeguarding investigation into allegations of neglect. The safeguarding referral noted Ms Y had right sided weakness with little to no feeling or sensation in her right side. There was a preliminary meeting in December and a safeguarding investigation meeting in January 2018. The Council acknowledges there was delay here and says it explained at the time that staff sickness had affected progress, though it says it should also have explained that within a short period of the incident it felt the Agency had provided a plausible explanation of what had happened.
30. Ms X attended both of these meetings, along with Council officers conducting the investigation. The minutes of the investigation meeting in January said the following.
- One of the carers wrote in the diary notes (kept in Ms Y's home) at 08:00 to 09:00 that Ms Y had red marks on her leg. The Council did not have copies of the diary notes, but Ms X had the original notes and would make them available after the meeting.
  - Ms X asked why, when the Agency's diary notes had an entry about red marks on the leg at 08:00, did nobody think this might be the reason Ms Y was distressed? She also wondered why there was no further mention of the leg until the paramedics were about to leave.
  - The manager of the Agency could not say why the carers did not spot the injury or why Ms Y was complaining of pain in her arm.
  - Ms X asked why a risk assessment had not been done as the bathroom was small. She felt her mother must have been left on the commode for a long time.
  - One of the carers thought the incident happened when Ms Y was on the commode next to the radiator.
  - The Agency's manager apologised to Ms X and said disciplinary measures were being used on the carers.
  - The allegation was substantiated.
31. A statement from the Agency's manager said:
- the two carers attending Ms Y did not notice the marks at the time, but had called the assessment manager to come back out because Ms Y was screaming because of pain which they thought was in her arm;
  - the assessment manager attended and noticed red marks on Ms Y's right leg but the carers could not recall anything about them;
  - one of the carers later said she thought the marks had occurred because the commode was placed next to the radiator. The commode did not have a side to it and would not stop Ms Y's legs touching the radiator. The bathroom was very small.
32. After the safeguarding meeting, the Agency held a 'lessons learned' meeting with the two carers and they were instructed to consider the position of radiators and assess whether there were any risks. If there were risks, an action plan would be put in place. The carers were told to have a more vigilant approach to observing their surroundings when completing tasks. The carers said they were trying to

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protect Ms Y's dignity as the bathroom door would not shut if they had placed the commode by the sink. The carers said they would take the commode and washing facilities into the bedroom in future.

33. The Council's complaint response apologised for the shortcomings in the service to Ms Y. It also apologised for the delay in the safeguarding investigation and for the delay in following up the 'lessons learned' with the Agency. The complaint response said:

*"ICare established the district nurses would be attending Ms Y that morning, after which the assessment manager left the property. ICare then had a call from the carers who said Ms Y was still distressed and upset. Due to this they felt they wouldn't like to leave her on her own and the assessment manager went back to sit with Ms Y. Whilst there, the carers assisted Ms Y off the commode, which is when the red marks were seen on her leg. Unfortunately, the carers could not be sure that the marks were not there when they had earlier assisted Ms Y to sit on the commode as they hadn't looked at her legs previously that morning..... after the paramedics arrived they completed an assessment of Ms Y's legs of which the medical information suggested that the marks had crusted over and were not fresh from that day".*

34. The Council told us:

- it was very sorry for the incident and had already apologised to the family. Its correspondence about the issue led to confusion, rather than providing a clear outcome and summary of events to reassure the family;
- the safeguarding meeting had to be postponed due to staff sickness and the Council had already apologised for the delay;
- the care plan did not specify Ms Y had no feeling in her right side. It was not known that should Ms Y sustain an injury to her right side, she may experience symptoms of pain but be unable to identify the source. This information only became known to the Agency after the accident;
- it accepted the risk assessment should have referred to the limited space in the bathroom;
- the burns may have appeared at first as red areas on the skin and worsened through the morning. Carers may have mistaken them for pressure areas that required medical attention, but not urgent attention. It was only obvious with the benefit of hindsight that the reason for Ms Y's distress was not, as she was indicating to professionals, because of pain in her arm, but as a result of an accident which led to a series of burns. There is not enough evidence to say the carers knew there had been a serious injury and failed to report it when contacting the district nurse;
- the recording of the incident lacked clarity, however this was a developing situation and carers prioritised supporting Ms Y over keeping a detailed running record;
- where there were concerns from the family about inconsistencies, these should have been explored more fully at the time.

35. The Agency told us:

- the carers overheard the paramedics say the red marks were not fresh and were crusted over. It did not know why the paramedics did not mention this in their report;

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it did not know Ms Y had reduced feeling in her right side; and

- Ms Y could communicate her needs.

## **Findings**

### **Failure to complete adequate risk assessments or provide safe care**

36. The Agency, which acted on behalf of the Council, was at fault because its staff did not deliver safe care in line with Regulation 12 of the 2014 Regulations. The fault caused Ms Y a serious injury and avoidable pain and distress. There was a failure to identify obvious environmental risks in Ms Y's home (small bathroom, hot radiator, proximity of commode to radiator) and to design a plan of care to minimise those risks. The Council accepts this fault. This was particularly important given Ms Y's vulnerabilities. We do not accept the Agency's assertion that Ms Y could always communicate her needs, because this contradicts her care plan which says she had dysphasia and sometimes had difficulty expressing herself. So, it was an additional risk that Ms Y might not be able to accurately communicate the source of any pain. We note the Agency's care plan did not mention Ms Y having reduced sensation down one side and the Council says this information only became known after the incident.

### **Failure to seek timely medical attention**

37. The records indicate Ms Y was in pain and distress and was saying the pain was from her arm. It is of grave concern that the carers did not seek urgent medical help, so that Ms Y could have some pain relief quickly. We acknowledge the carers took some steps to report their concerns by calling the office and the district nurse for medical input, but what is not in dispute is Ms Y's pain and distress, whatever the cause and source of that pain. The appropriate response by the carers should have been to take immediate action to ensure she had pain relief. Urgent medical help was not sought for several hours and was fault by the Agency, which acted on behalf of the Council. We accept the Council's position that the red marks may have changed in their appearance during the course of the morning, that Ms Y's reduced pain sensation was not known at the time and that she was saying her arm hurt. But we do not consider this absolves the Agency from its responsibility to deliver safe care, part of which was ensuring there was no delay in Ms Y receiving pain relief.
38. The district nurse's records strongly suggest carers had told her they wanted her to look at Ms Y's 'pressure areas'. The paramedics too seem to have been informed of the weals just as they were leaving, rather than having been told about them on arrival. We reject the Council's position that there is insufficient evidence to conclude carers were not open and transparent about Ms Y having sustained a serious injury. We consider the carers should have been clear when calling medical assistance that: Ms Y had red weals on her leg; it was documented on her care plan that there was no known history of pressure sores; that she was complaining of pain in her arm and was distressed and that she had dysphasia. We consider the Agency and its care staff failed to act in line with Regulation 20 (the duty of candour) by suggesting Ms Y had pressure areas and not providing a full picture of Ms Y's condition. The failure to give full information meant there was a missed opportunity for the district nurse to give comprehensive advice based on possession of full information, and a missed opportunity for Ms Y to receive pain relief sooner. There was a delay of between two and three and a half hours in Ms Y getting pain relief as this was not administered until the paramedics attended after 11.30. The delay in seeking urgent medical help was a

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failure to deliver safe care and work effectively with health professionals, as required by Regulation 12 of the 2014 Regulations and so was fault.

### **Failure to provide an accurate account of what happened**

39. There are inconsistencies in the Agency's account of what was known about the injury and when. When interviewed by a manager of the Agency after the event, both carers said they did not notice anything at the time. This contradicts their contemporaneous record which noted red weals on Ms Y's leg at 08:00. And the Council's complaint response also said the carers did not know about the marks until they changed Ms Y's clothes when the assessment manager returned later in the morning. These cannot be accurate statements by the carers or the Council because, as set out above, the contemporaneous notes indicated both carers were aware of the red marks because of their initial entry in the case records. And the assessment manager must also have been aware of the red weals when she arrived at Ms Y's home because she would have seen the carer's entry at 08.00 referring to them, before writing her own notes. We are satisfied the available evidence suggests both carers and the assessment manager knew about the red weals earlier than the complaint correspondence suggests. And, we consider the complaint response was also misleading because it stated the paramedics thought the marks had crusted over and were not fresh from that day, suggesting the carers were not responsible. We note the Agency's position that the carers overheard the paramedics say the marks were not fresh. But the paramedics did not say this in their report and, as the paramedics' attendance notes are detailed, it is reasonable for us to conclude that they would have included this in the report. On balance, we find the statement from the Agency about the marks being not fresh, which is repeated in the Council's complaint response, as well as the suggestion that carers did not know about the marks until they changed Ms Y's clothes, to be misleading and a breach of the duty of candour and therefore fault.

### **Failure to complete a timely safeguarding investigation or consider and assess relevant evidence**

40. During the safeguarding meeting, Ms X raised concerns about inconsistencies between the carers' contemporaneous records and their later accounts of what happened. Officers responsible for conducting the safeguarding investigation failed to examine the original records which had been retained by Ms X's sister who offered to provide them. This was fault.
41. We consider the Council missed an opportunity to follow up additional concerns that the carers did not seek prompt medical attention for Ms Y and so we do not regard the safeguarding enquiry to have been as thorough as it should have been. Statutory Guidance explains one of the purposes of a safeguarding investigation is to establish facts and address what has caused abuse or neglect. We do not see how this can be achieved without proper consideration of all the relevant evidence and so was fault. There was also delay in completing the safeguarding investigation, which the Council has acknowledged, and which was fault.

### **Agreed action**

42. 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, although we found fault including in the actions of the Agency, our recommendations are for the Council.

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43. The Council has already apologised for the delay in the safeguarding investigation and a manager from the Agency apologised to Ms X during the meeting. This is a partial remedy.
44. Ms X considers her mother suffered a significant loss of independence and a decline in her health due to the failings in care described above. She believes Ms Y would not be in residential care but for the Council and Agency's failings. We cannot be satisfied on a balance of probability that Ms Y would not have needed residential care in any event as her health was already seriously compromised before the incident described in this report.
45. The payments we recommend are not like the damages or compensation a court awards for a personal injury, but a reflection of avoidable distress as a result of fault. Our [Guidance on Remedies](#) suggests payments for distress of up to £1,500 where harm has occurred. But, in exceptional circumstances, such as where there was significant harm over a prolonged period, we may recommend a higher payment. We are satisfied this case is exceptional because the failings in Ms Y's care led to a serious burn causing pain and distress and a hospital admission that was directly attributable to the injury and subsequent complications when the wounds became infected. To reflect the avoidable distress, we recommend the Council apologise and pays:
- £5,000 to Ms Y; and
  - £500 to Ms X.
46. We also recommend the Council ensures in future that risk assessments completed by care agencies acting on its behalf identify obvious environmental hazards and care plans are put in place to minimise risks. The Council should also conduct regular quality assurance checks with the Agency to satisfy itself the Agency is implementing effective risk assessments to ensure clients are safe.
47. The Council has agreed to complete the recommendations in paragraph 45 within one month of this report. It has agreed to complete the recommendation in paragraph 46 within three months. We will require evidence it has done so.

## Decision

48. Ms X complains for her mother Ms Y about burns to Ms Y's legs sustained during personal care at home. We uphold the complaint. Ms Y's care was neither safe nor in line with Regulation 12 of the Health and Social Care (Regulated Activities) Regulations 2014. The Council's safeguarding investigation was delayed and failed to consider relevant evidence. The Council and Agency have taken some appropriate action including an apology and a review with relevant staff. In addition, the Council will:
- apologise in writing for not following up relevant evidence that could have added to the safeguarding investigation;
  - make payments to Ms X and Ms Y to reflect their distress;
  - ensure its contractors complete adequate risk assessments; and
  - conduct regular quality monitoring of the Agency focusing on whether it is implementing effective risk assessments.
49. 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

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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*)