Local Government & Social Care OMBUDSMAN

Report by the Local Government and Social Care Ombudsman

Investigation into a complaint against

Royal Borough of Windsor and Maidenhead Council

(reference number: 18 015 872)

25 August 2020

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 X	The complainant
Mr Y	His father
Mrs Y	His mother
Ms Z	His sister
Optalis	agency which provides the Council's adult social care
Bespoke	care provider
Carewatch	care provider

Report summary

Adult social care – home care

Mr X complains on behalf of his late parents. He says the Council did not properly consider the risks of separating them after 59 years of marriage or of Mr Y living on his own. He complains about the quality of care it provided to them both and says it did not deal adequately with his concerns and complaints. He also complained that the safeguarding process was flawed, and the Council would not give him a copy of Mr Y's assessment.

Finding

Fault found causing injustice and recommendations made.

Recommendations

To remedy the injustice caused, we recommend the Council:

- apologise to Mr X and Ms Z setting out the faults identified in this report and the action the Council will take, or has taken, to put this right;
- pay Mr X and Ms Z £750 each to recognise the distress it caused in failing to properly consider the risks of separating Mr and Mrs Y;
- pay Mr X a further £500 for the time and trouble and distress he was caused in bringing his complaint;
- review any cases where couples are separated by their care needs, to ensure the risks and human rights were fully considered for both parties. Also, that adequate contact is included on the care and support plans;
- review assessment practice across the Council to ensure it is consistent and Care Act compliant. It should do this using the quality measures and reporting processes it has implemented since these events;
- ensure it has an effective mechanism for following up where complaints about poor practice have been received and to check that improvements are made and sustained;
- put in measures to ensure complaints about several agencies receive a coordinated response; and
- review its commissioning practice when services are rated "Requires improvement" to ensure it considers any increased risk to people.

The complaint

1. The complainant, whom we shall refer to as Mr X, complains that the Council:
   - did not properly consider the risks in supporting Mr Y to remain at home on his own;
   - did not properly consider the impact of separation after 59 years on Mr Y and his wife, Mrs Y;
   - did not provide Mr X with a copy of Mr Y's assessment;
   - did not provide an adequate quality of care to Mr Y;
   - carried out a flawed safeguarding process; and
   - did not deal adequately with Mr X's concerns and complaints.
2. Mr X says the whole process has been distressing for him and his family. Mr Y was devastated at being separated from Mrs Y; he experienced poor care as well as being on his own, and this badly affected his quality of life. Although Mrs Y was less aware, she was more disrupted than she needed to be because Mr Y was not there with her. Mr X spent a lot of time and trouble dealing with the various issues and ultimately, with his complaints. Mr and Mrs Y have since died.

Legal and administrative background

3. 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)***
4. 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)

   In this case, Mr X was attorney for Mr Y and we consider him a suitable person to complain on his behalf.
5. This case involves three commissioned agencies, Optalis, which provides the Council's adult social care, and Bespoke and Carewatch who are care providers. 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 with the service of the agencies, we have made recommendations to the Council.

The Care Act

6. The Care Act 2014 (the 2014 Act) sets out local authorities' duties around adult social care. The Care and Support Statutory Guidance sets out how the Care Act should be applied.

Assessment, eligibility, and support planning

7. Sections 9 and 10 of the 2014 Act say local authorities must assess the needs of any adult who appears to need care and support. Authorities must do this regardless of whether they think the person has eligible needs and regardless of the person's finances. They must involve the person and their care worker or any other person they might want involved.

8. Local authorities must carry out the assessment over a suitable and reasonable timescale considering the urgency of needs and any variation in those needs. They should tell the individual when their assessment will take place and keep the person informed throughout the assessment. An assessment must always be appropriate and proportionate and can be combined with another person.

9. Where a local authority determines that a person has eligible needs, it must meet these needs. It must also give the person a copy of its decision.

10. The 2014 Act also places a duty of promoting individual wellbeing on local authorities. It sets out nine areas of wellbeing which include:

    - physical, mental and emotional health;
    - domestic, family and personal relationships;
    - personal control; and
    - suitability of living arrangements

11. The following requirements are also relevant to this case. Local authorities must:

    - consider how to prevent needs developing or escalating at every interaction with a person;
    - take a person centred approach to assessment and balance the person's own view with that of others;
    - place prevention and early intervention "at the heart of the care and support system";
    - complete a person centred and person-led care and support plan and provide a copy to the person. It must ensure the principles of promoting wellbeing and preventing or delaying the development of needs is reflected in the plan.

12. The statutory guidance says "The core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life".

Mental capacity

13. The Mental Capacity Act 2005 (the 2005 Act) sets out how to decide for people who lack the mental capacity to decide for themselves. The 2005 Act and the Code of Practice (2007) describe the steps a person should take when dealing with someone who may lack capacity to decide for themselves. They describe when to assess a person's capacity to decide, how to do this, and how to decide on behalf of someone who cannot do so themselves.

14. A person must be presumed to have capacity to decide unless it is established that they lack capacity. When someone's capacity is in doubt a council must assess their ability to make a decision.

15. The 2007 Code of Practice says:

- Capacity should always be reviewed:
  - whenever a care plan is being developed or reviewed;
  - at other relevant stages of the care planning process; and
  - as particular decisions need to be made.
- The person who lacks capacity is at the centre of the decision to be made. Their wishes, feelings, beliefs and values should be taken into account, but the final decision must be based entirely on what is in the person's best interests.
- The decision-maker will need to find a way of balancing disagreements over best interests or deciding between them. Ultimate responsibility for working out best interests lies with the decision-maker.
- If there is a serious disagreement about the need to move the person that cannot be settled in any other way, the Court of Protection can be asked to decide what the person's best interests are and where they should live.
- "Any staff involved in the care of a person who lacks capacity should make sure a record is kept of the process of working out the best interests of that person for each relevant decision, setting out:
  - how the decision about the person's best interests was reached
  - what the reasons for reaching the decision were
  - who was consulted to help work out best interests, and
  - what particular factors were taken into account".

Human rights

16. The Human Rights Act 1998 (the 1998 Act) sets out the fundamental rights and freedoms that people can expect.

17. Article 8 of the 1998 Act says everyone has the right to respect for their private and family life, their home and their correspondence. Public authorities may be obliged to actively protect rights under this article and may interfere with these rights to protect the rights of other people or the public interest. The public authority must interfere with the right as little as possible.

Complaint handling

18. Our "Principles of complaint handling in combined authorities and devolved settings" says:

- "Where more than one organisation is involved in the complaint, they work together to provide a single, coordinated response".
- "Those responding to complaints have the authority and expertise to get at the facts and recommend remedies".
- "There is 'no wrong door' for complaints. People can make a complaint without needing to understand and navigate the roles and responsibilities of the different bodies".
- "There is a seamless route to redress…".

The Care Quality Commission

19. The Care Quality Commission (CQC) is the statutory regulator of care services. It keeps a register of care providers who show they meet the fundamental

standards of care, inspects care services and issues reports on its findings. It also has power to enforce against breaches of fundamental care standards and prosecute offences.

20. CQC inspected Carewatch (Windsor), on 13 June 2018. This inspection found the service required improvement in four of the five areas inspected and was inadequate in the remaining area. It rated the service "requires improvement" overall. Some of the issues identified in this inspection reflect some of the issues raised about Carewatch during the events described below.

21. A follow up inspection in January 2019 found some improvements but the overall rating remained "requires improvement". This service was run by Carewatch Care Services Limited which ceased trading early in 2019 and went into administration.

How we considered this complaint

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

23. 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

24. Mr and Mrs Y were married for nearly 60 years and lived at home. Mr Y cared for Mrs Y. Her health and disabilities caused her various difficulties including with hearing, mobility, and understanding. Mr Y had difficulties with pain, mobility and frailty. For some time, Mr X and his sister, Ms Z, visited daily to help Mrs Y to bed and provide general support but in late 2016 they could not continue.

25. Optalis assessed Mrs Y in January 2017 and she received a package of care from Bespoke. The assessment noted Mr Y was providing Mrs Y with background support and was to have his own assessment. Optalis assessed Mrs Y again in March 2017 and noted Mr Y could no longer help her with dressing or with feeding. It also noted the need to consider Mrs Y's mental capacity as she was only able to make simple choices. Mrs Y began attending a day centre for social stimulation and to give Mr Y a break from his caring role. In August 2017 the Council completed an initial assessment for Mr Y. It identified a need for social inclusion. Mr Y began attending a social club regularly and the Council closed his case.

26. In January 2018, Mr and Mrs Y were both admitted to hospital.

Mrs Y's story

27. Mrs Y was dehydrated and had diarrhoea when she was admitted to hospital. She was discharged home after a few days with an increased care package but readmitted to hospital the following day.

28. Ms Z reported concerns about the care Mrs Y had been receiving from Bespoke. She said Mrs Y was "very irritable" and was refusing to drink or just taking sips. She did not believe care workers were prompting Mrs Y with fluids, did not stay the full time and may have fed her food which was too hot as Ms Z thought Mrs Y had a burn on her tongue. The Council completed a safeguarding enquiry. It identified that:

- calls were between 5 and 40 minutes short. On one occasion Mr and Mrs Y lost a total of one and a half hours in one day which the Council noted was significant and could have been used to prompt them with fluids;
- care logs did not record care workers prompting Mrs Y with fluids;
- care workers had not identified Mrs Y's burnt tongue.

29. The Council told Bespoke it should complete the time it was paid for and effectively record the actions completed. Bespoke put a food and fluid chart in place to monitor intake. The Council substantiated the concerns about the call times but not the concerns about the burnt tongue. It was possible the burn happened at the day service Mrs Y attended.

30. The Council noted four calls a day would no longer meet Mrs Y's needs and she needed 24 hour care. Mrs Y's case notes state that her family wanted a live-in care worker or care home placement. The notes say "We also discussed the option of long term care for mum, however [Ms Z] is concerned that this would impact on both her mother's and father's mental health and wellbeing as they have been married for a significant amount of time". At this point the Council told Ms Z it might not meet the cost of a live-in care worker and discussed the possibility of combining Mr and Mrs Y's budgets.

31. In March, Optalis assessed Mrs Y in hospital. It noted she had been in hospital twice recently for dehydration, diarrhoea and a urinary tract infection. She now needed two people to support with personal care in the mornings. The assessment also noted Mr and Mrs Y had been married for many years and it was important to them both to remain together. It said Mr Y had declined since Mrs Y had not been at home.

32. The family discussed the possibility of live-in care with the Council. Council records note a proposal to use a direct payment for both Mr and Mrs Y and fund a live-in care worker. The family mentioned the possibility of topping up the Council funding if it was not enough. Mr Y's support plan, dated 8 March, says the Council was waiting for the family to come back about this.

33. On 12 March, the social worker emailed the operations manager. She gave an outline of the case and said "[Mrs Y] and her husband have been married for over 50 years and the importance of remaining together appears important to both [Mr and Mrs Y]. [Mrs Y] will noticeably react to her husband's visits to her in hospital placing his face in both her hands. [Mr Y] has also noticeably declined since [Mrs Y] has not been at home, becoming withdrawn and less able to manage his personal care and nutritional needs". The social worker said she had completed a care needs assessment, mental capacity assessment, and a best interests decision but said "these have not been recorded yet". Our investigation found no evidence of these. The social worker said it was hoped that a direct payment for both Mr and Mrs Y would be enough to cover the cost of a live-in care worker but this takes a long time to arrange. She asked the manager to agree to a nursing home placement for Mrs Y until this could be arranged. The manager agreed, so Mrs Y was admitted to the care home.

34. On 20 March, the social worker phoned Ms Z to advise that Mrs Y had settled into the care home and was eating and drinking well. They discussed a possible return home, but Ms Z was undecided. She could see the benefits for Mrs Y but was unsure how Mr Y would feel. They agreed to wait until the family had discussed this and make a best interests decision about Mrs Y's long term care. That same day, the Council recorded Mrs Y's placement as permanent.

35. The Council also completed a safeguarding enquiry following a fall at the care home. We have not included any further information about this as it found no cause for concern and completed the process effectively.

Mr Y's story

36. In January 2018, three days after Mrs Y, Mr Y was also admitted to hospital with dehydration.

37. When Mr Y was ready for discharge, Mr X complained that home was not a suitable place for him. He asked Optalis to send a copy of Mr Y's assessment electronically. Eventually it sent an electronic copy but gave him the wrong password. Mr X asked for the correct password but Optalis did not respond and Mr X did not see the assessment. In fact, the Council did not complete an assessment of Mr Y although it provided us with support plans which it referred to as assessments.

38. The Council says Mr Y was clear with staff that he wanted to go home from hospital. Mr Y went home with a package of care from Bespoke. Shortly after, Mr Y was again admitted to hospital.

39. Mrs Y was still in hospital at the beginning of March. As another team was responsible for Mr Y, her social worker requested a review of his care package. Council notes say "[Mrs Y's social worker] is aware that separating [them] will have a severe impact on both [their] mental health – if [Mrs Y] was placed in residential care she would be constantly asking for [Mr Y]". The social worker "would like to consider the possibility of a live-in care worker who would meet both [their] care needs and would be a more financially economical solution to their joint care needs". Ms Z advised that Mr Y was "very low" as Mrs Y was in hospital. She said he was not eating or drinking properly and had lost a lot of weight.

40. On 6 March, a student social worker visited Mr Y at home for a "review assessment". This noted some background details and that Mr Y currently received three 30-minute care calls every day. The student social worker noted the way forward was the possibility of Mrs Y being discharged home with support to meet both their needs. Mr Y's support plan said Mr Y was unable to continue caring for Mrs Y "but would like to continue living with his wife". Also, Mr Y used to enjoy going to a social club "but since [Mrs Y's] admission to hospital six weeks ago has not been willing to go out. Family report he spends a lot of time in bed". She noted there were no changes needed to the support plan.

41. In mid-March, Mrs Y moved into a care home while Mr Y remained at home. At the end of March, Mr Y was admitted to hospital with sepsis and acute kidney infection.

42. Early in April, while Mr Y was still in hospital, Ms Z asked about him going into the care home with Mrs Y. The social worker told him Mr Y would have to be assessed as needing 24 hour care and agree to it. The social worker spoke to Mr Y and noted that he asked about Mrs Y and said he had only been to see her once since she moved into the care home. She also noted that she asked Mr Y if he would like to go to "somewhere like" the home where Mrs Y was, and he said he wanted to go to his own home.

43. Mr Y was discharged home after around three weeks, following an Occupational Therapist (OT) assessment. The Council increased his package of care to four calls daily. It asked Bespoke to encourage Mr Y to eat and drink and to ensure this was documented on food and fluid charts.

44. Mr Y was readmitted to hospital the following day. The ambulance service raised a safeguarding alert citing concerns of neglect and acts of omission. A care worker had visited and was not able to help Mr Y to mobilise as he was too weak and unstable and there were no mobility aids available. Mr X says he was not aware of this safeguarding concern. The Council says it will apologise as it has no record of advising the family of the concern or outcome.

45. A support plan for Mr Y said he had not been eating or drinking enough and was struggling with personal hygiene. He "suffers with low moods and is taking antidepressants" also that he "has lost a lot of weight". Mr X raised concerns that:

- Mr Y was not eating and drinking;
- his bedtime calls were early;
- he was depressed and missing Mrs Y;
- Mr Y had been in hospital three times in two months and Mr X felt he would end up dead if they did not break the cycle.

46. The social worker said they would need to meet in the hospital and plan Mr Y's discharge once all reports were completed and he was medically fit.

47. The hospital would not discharge Mr Y until an OT had visited his home to assess it and he had support in place. The deputy head of nursing considered the safeguarding concerns and emailed the lead nurse for safeguarding. She said the "comprehensive" OT report had identified risks around loneliness, malnutrition and engagement if Mr Y was discharged home. She said there were no clinical findings other than chronic conditions and he did not need hospital for these. She also said there was shared learning on this case because his wife was in a care home and his family had raised concerns about him returning home and being left alone. The OT discussed plans with the family and they said they would like Mr Y to be at home with Mrs Y because of his depression due to being away from her. They said Mr Y would end up back in hospital if discharged home without 24-hour care.

48. Mr X says he and Ms Z were slightly late to the meeting at the end of April to discuss Mr Y's care. The Council says Mr X and Ms Z were 30 minutes late to the meeting. Mr X was disappointed to find the meeting had already discussed care plans with Mr Y and they were told Mr Y wanted to return home. He says later in the meeting, officers used leading questions such as "you want to go back and live in your bungalow don't you?". Council records note "Spoke to [Mr Y] previous to meeting he explained that he wished to go home to his bungalow". The OT said she felt Mr Y's needs could be met at home with care workers. She said she would order a hospital bed for him and do a home assessment. The family expressed concerns about Mr Y's low mood, missing Mrs Y and not eating or drinking enough. Also, the risk of falls, the time of the care calls, and that care workers were not staying the allocated times. The social worker said Mr Y did not try to get up unattended and would wait until care workers came to help. The Council increased the length of the calls so that care workers had enough time to prompt Mr Y with food and drink. Mr Y's care calls now totalled three hours daily over four calls.

49. Mr X wrote to the Council and said it had given no consideration to Mr and Mrs Y being married for nearly 60 years. Mr Y would spend his days sitting in the same chair all day except when care workers visited and helped him to the toilet. He asked when Mr Y would have support to visit Mrs Y. The Council said "We understand and empathise with your father's current situation with regard to being

separated from his wife and would like to explore providing support for him to visit her regularly". It said it would not be appropriate for Mr Y to move into a care home. "This has been established through assessments carried out by both Health and Social Care professionals". It said if the family could no longer support Mr Y there were voluntary organisations that could help with shopping and he could pay privately for cleaning and ironing. Voluntary organisations could also provide a befriending service if Mr Y wanted company at home. Our investigation did not find any adequate assessments for Mr Y.

50. A support plan dated 1 May noted Mr Y had been re-admitted to hospital 24 hours after discharge and this was his third admission this year. It said he wanted to return home and was able to make his own decisions but may need family for support. It also noted family felt he should go to the same care home as Mrs Y. It said "steps taken to address any difficulties and risks" and "care is also encompassing of social needs and his long marriage to his wife who resides at [the care home]". On 3 May, the Council arranged for Carewatch to take over from Bespoke as Bespoke could not restart at the required time.

51. On 10 May 2018, Mr Y was discharged from hospital again. The next day, Mr X emailed the social worker to say he had visited Mr Y the night before and found him in urine-soaked clothes and pad from that morning. He had helped him to bed. A care worker from Carewatch had visited and left before Mr Y returned from hospital. Family provided him with an evening meal as he had none, and when a carer turned up at 8:20pm (40 minutes early), Mr Y had said it was too early to go to bed so was left fully clothed in his chair. The care worker stayed 10 minutes, not the required 30, and did not toilet Mr Y, left all the lights on and left Mr Y's walking stick far from his chair. Mr Y tried to get this unaided as he had been sent home without a walking frame. Mr X said there were no food and fluid charts in place. The Council followed up with Carewatch about the failed visits and lack of food and fluid charts, and with the hospital to get the walking frame delivered. A social worker visited and noted Mr Y was happy to be at home. She explained to Mr Y what the care workers should do during each call and spoke to Carewatch to stress that Mr Y should be helped to bed on the last call. She asked Carewatch to arrange for the quality officer to visit Mr Y and this also took place the same day.

52. On 16 May, the Council completed a risk assessment for Mr Y to go and visit Mrs Y twice a week with a care worker. It agreed a total of three hours weekly for the two visits to Mrs Y.

53. Sadly, towards the end of May, Mr Y collapsed and died in his home with a care worker present. The care worker called an ambulance. A few minutes later he realised Mr Y was not breathing and called back; the ambulance arrived at this point.

54. The ambulance staff asked the care worker if he had performed cardiopulmonary resuscitation (CPR). The care worker said he had been told by Carewatch not to perform CPR at all. Because of this the ambulance service raised a safeguarding alert with the Council.

55. The safeguarding investigation found the allegation was not substantiated. We have not included all the detail here but have considered the chronology and all the information available. We found the safeguarding enquiry was satisfactorily concluded within a reasonable timescale given the nature of the investigation.

56. We asked for Carewatch's daily notes for Mr Y, but these were not provided. We did receive Carewatch's individual needs assessment dated 11 May 2018 as

completed by the quality officer. This included care plan information such as "ensure eats and drinks plenty", "complete food and fluid chart", "leave plenty of fluids on table beside". The purpose of the evening call is noted as "Help me get ready for bed and into bed" and the plan includes "assist me to commode and wash and change my pad". We also received various other documents which appeared to provide comprehensive information necessary to provide care to Mr Y. We did not receive any documents relating to the first day of Carewatch's responsibility for Mr Y's care.

57. When we asked about the lack of adequate Care Act assessments for Mr Y, the Council told us it had experienced high staff and management turnover. Mr and Mrs Y, who were under different teams, experienced different approaches to assessment. Since then, the Council says it has implemented various quality measures and is working to achieve a consistent level of best practice. It acknowledges that it failed to assess the impact of separating Mr and Mrs Y. The Head of Service now ensures that service managers are aware to check joint issues, potential risks and impacts when assessing couples. We are pleased to note these improvements.

Complaint handling

58. The Council's initial responses to Ms Z's complaints about the quality of care provided to Mrs Y, and Mr X's complaints about the quality of care provided to Mr Y, are detailed above within the individual stories.

59. Mr X raised many complaints some of which we have not detailed above but which included issues around:

- delivery of a bed;
- difficulty with Mr Y accessing transport to the day centre;
- Carewatch not sharing information despite being advised by Optalis that it should do so.

60. Due to the varied and ongoing nature of these complaints, Mr X dealt with several people across the different agencies.

61. Several of the issues were not dealt with as formal complaints. As a result, Mr X received various responses but no final conclusions until he sent in a detailed list of the issues he considered outstanding. By this stage, the complaint had become unwieldy and confusing for both Mr X, the Council and the agencies involved. Mr X felt his complaint had not been adequately considered. This investigation is the first point at which all the issues were brought together.

62. There is too much information about the complaints handling to detail it in this report so we have only mentioned some events which illustrate the difficulties. We have considered all the correspondence and records in coming to a decision.

63. In dealing with Mr X's complaints about the care workers' actions when Mr Y died, Carewatch inadvertently told Mr X that the deputy manager was to attend a coroner's hearing for Mr Y. When Mr X chased for information about this, Optalis advised him that the Coroner's office had confirmed there had been no post-mortem or further investigation. The deputy manager had fabricated the appointment.

64. The Council advised Mr X that Carewatch had been subject of serious concern and Optalis had been supporting it to improve performance. Additionally, two managers were found to be inappropriately employed with Carewatch and left on

the day this came to light. Mr X said he wanted Carewatch decommissioned; the Council advised him that was its main care provider so this would not happen. Mr X could not understand why this was not an option when the quality of care was so poor and not disputed.

65. On 4 December 2018, Optalis responded to Mr X's complaint about Mr Y returning home. It said:

- two hospital practitioners had spoken to Mr Y to explore his wishes around the care he received and where he would be discharged. The family had not resisted this happening and it is good practice to understand the wishes of the person concerned;
- due to Mr Y's low mood, the practitioners may have come across as directive but this was necessary to facilitate discharge planning;
- when the OT spoke to Mr Y, he wanted to go home;
- the professionals concerned had no reason to doubt Mr Y's mental capacity and he was therefore able to decide to return home. Due to concerns from the family, the care package was increased;
- Mr Y had told the practitioner that he was happy at home and care was working in May 2018. They also discussed social inclusion support so that he could visit Mrs Y in the care home;
- all concerns about Carewatch had been shared with the quality team who were working with the Agency to improve processes;
- there were inconsistencies in the events leading to Mr Y's death but the care worker was not asked to perform CPR and therefore there was no need to investigate further.

66. It apologised to Mr X for not providing the correct password and failing to send the assessment and said this had been addressed with the staff concerned.

67. In March 2019, following further correspondence with Mr X, the Council wrote with a further response about the investigation into the care workers' actions when Mr Y died. It said:

- Carewatch did not train staff to carry out CPR and this was acceptable. Staff were trained to call 999 and follow the instructions given;
- the two managers left the company on the same day the Council raised serious concerns and were replaced immediately;
- there was no delay completing the minutes of the discharge meeting but in sending them to Mr X.

Conclusions

The assessments

68. It is not our role to decide if a person has social care needs, or if they are entitled to receive services from the Council. Our role is to establish if the Council assessed a person's needs properly and acted in accordance with the law. In this case, the Council failed to do so.

69. The Council took seven months from January to August 2017 to assess Mr Y's needs in his own right. This was too long. It was at fault here and this meant

Mr Y's needs were not adequately met for many months putting him at an avoidable, increased risk of harm.

70. We have not found any adequate assessments which properly considered Mr Y's needs in line with the Care Act (as outlined in paragraphs 6 to 12) following his admission to hospital in January 2018. This is fault. As a result, there was no consideration of the risk to Mr Y despite the numerous concerns raised by family and the social workers. We would expect the consultation with Mr Y's family to openly discuss the options so Mr Y understood and could make an informed decision. This did not happen despite the support plan noting that he may need family to support with this.

71. The Council did not give due consideration either to a live-in care arrangement, or a placement with Mrs Y, despite having said it would. This meant the Council could not be clear about the support Mr Y needed or that it met his needs adequately. The Council's records suggest it left the decision with the family at one point, but it is the Council's responsibility to ensure needs are met. We do not know if Mr Y would have decided to go home had a full discussion taken place. Professionals did not dispute Mr Y's health and wellbeing was being badly affected by the separation from Mrs Y. We have therefore decided this caused Mr Y significant and undue distress and risk of harm. On the balance of probabilities, it also caused him actual harm as all accepted this contributed to his worsening condition.

72. We have also not found any evidence of the decision for Mrs Y's residential placement to become permanent. This is fault. Although Mrs Y seemed to settle well in the care home, we cannot know whether she would have been better had she stayed with Mr Y. We also cannot know whether this caused her distress, but the social worker said there was a risk to her if separated from Mr Y. Mr X also said the transfer to the care home would have been smoother had she been with Mr Y. We are therefore satisfied this caused her to be at an increased, and undue, risk of harm. Mrs Y did not have capacity to decide about her own care so a best interests decision was needed for this. This should have balanced professionals' views with those of the family and Mrs Y's likely view where known. We have seen no record of a best interest decision. This is also fault and means the Council could not be clear whether the action it took was in Mrs Y's best interests.

73. Mr Y's separation from Mrs Y due to her move to the care home and the expressed concerns about this, engaged article 8 of the Human Rights Act. We have not seen any evidence that the Council considered whether it was appropriate to limit this right in the circumstances, or any consideration of their human rights at all. The Council's failure to demonstrate how it had given regard to its responsibilities around this is fault. The Council's failure to adequately assess means that despite many concerns about his need to be with his wife, nothing was in place to ensure Mr Y had this opportunity. Two months after she moved to the care home, the Council agreed to arrange support for Mr Y to visit her. This was just over one week before he died. This fault caused significant and undue stress, frustration and outrage to Mr X and Ms Z as they repeatedly raised their concerns.

74. Sadly, Mrs Y has also now died, and we cannot therefore put right the injustice caused to her and Mr Y.

Quality of care

75. It is clear from the evidence that Bespoke provided a poor service to Mr and Mrs Y prior to January 2018. This was fault. Care workers cannot force people to drink or eat, so we do not know whether Mr and Mrs Y would have done so if the care workers had provided adequate support. However, the failure to provide the care as planned put Mr and Mrs Y at an increased and undue risk of harm.

76. Mr Y was also left without the care he needed from Carewatch. This was also fault and caused Mr Y to be at an increased and undue risk of harm. On the balance of probabilities, this is also likely to have caused him some distress.

Complaint handling

77. When Ms Z complained about the care being provided when Mrs Y first went to hospital in January 2018, the Council took appropriate action and we found no fault in this element or in the way it dealt with the complaints which resulted in safeguarding enquiries.

78. However, the arrangement with Optalis and Carewatch caused much confusion for Mr X. The Council did not satisfactorily explain this and it appeared to Mr X that the Council was being difficult. All his complaints were linked but we saw no evidence the Council, or the agencies concerned, considered dealing with them as one. The Council also did not adequately deal with Mr X's level of involvement. Due to his high level of concern, Mr X expected more information and engagement than many complainants, and neither the Council nor the agencies managed this well. They should have involved him fully and kept him actively informed or managed his expectations and explained what they could do and when. This would have helped him know what to expect and what questions to ask. This was fault and caused Mr X significant and undue time and trouble, stress and outrage.

Recommendations

79. 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)***

80. To remedy the injustice identified above, we recommend the Council:

- apologise to Mr X and Ms Z setting out the faults identified in this report and the action the Council will take, or has taken, to put this right;
- pay Mr X and Ms Z £750 each to recognise the distress it caused in failing to properly consider the risks of separating Mr and Mrs Y;
- pay Mr X a further £500 for the time and trouble and distress he was caused in bringing his complaint;
- review any cases where couples are separated by their care needs, to ensure the risks and human rights were fully considered for both parties. Also, that adequate contact is included on the care and support plans;
- review assessment practice across the Council to ensure it is consistent and Care Act compliant. It should do this using the quality measures and reporting processes it has implemented since these events;

- ensure it has an effective mechanism for following up where complaints about poor practice have been received and to check that improvements are made and sustained;
- put in measures to ensure complaints about several agencies receive a coordinated response; and
- review its commissioning practice when services are rated “Requires improvement” to ensure it considers any increased risk to people.

Decision

81. We have completed our investigation and uphold Mr X’s complaints that the Council:
    - did not properly consider the risks in supporting Mr Y to remain at home on his own;
    - did not properly consider the impact of separation after 59 years on Mr Y and his wife, Mrs Y;
    - did not provide Mr X with a copy of Mr Y’s assessment;
    - did not provide an adequate quality of care to Mr Y;
    - did not deal adequately with Mr X’s concerns and complaints.
82. We do not uphold Mr X’s complaint that the Council carried out a flawed safeguarding process.