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PUBLIC SERVICES OMBUDSMAN FOR WALES

The investigation of a complaint against Wrexham County Borough Council

A report by the
Public Services Ombudsman for Wales
Case: 202100024

Contents

Introduction

This report is issued under s23 of the Public Services Ombudsman (Wales) Act 2019.

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Mrs X and her sister as Ms Y.

Summary

Mrs X complained that the Council failed to provide appropriate and adequate support to her sister, Ms Y, in the months leading to her death, including whether information was shared appropriately between the Council and a third-party organisation providing services on behalf of the Council ("the Provider"), and whether the Council took appropriate action in relation to any information shared.

Ms Y, an adult with learning disabilities, had lived with and been cared for, by members of her family all her life. Mrs X approached Social Services with a view that Ms Y should lead a more independent life and a series of assessments took place to determine appropriate living accommodation for Ms Y. Ms Y's alcohol consumption was a long-standing problem which Mrs X relayed to the Council as one of her main concerns. Ms Y moved into supported living accommodation in April 2019. The Council entered into a contract ("the Contract") with the Provider to provide on-site daily care/support to the residents in the supported living accommodation, which included Ms Y.

The Ombudsman found that despite mounting concerns about Ms Y in terms of her regular refusal of support, about the state of her flat, and around her drinking, the Provider did not escalate these concerns to the Council until March 2020. The Contract clearly set out the circumstances in which matters should have been escalated to the Council, and the threshold for raising concerns had been met several weeks before March 2020. When the Provider did contact the Council in March and April 2020, they were unable to access help/advice. Whilst this was at the period marking the beginning of the COVID-19 lockdown, the Provider should have been able to access help/advice. Ms Y sadly died in April 2020.

Whilst the Provider was under contract to provide services on behalf of the Council, the Council remained responsible for the delivery of services to Ms Y. The Council should have ensured it monitored the delivery of this service to make sure it met Ms Y's needs as outlined in her care package, and if not, it could have arranged a service review.

The Ombudsman was satisfied there were several failings in Ms Y's case, namely the Council's management of its approach to Ms Y's drinking problem, the failure by the Provider to escalate matters to the Council in accordance with the terms of the Contract, and when concerns arose about Ms Y, the Council's failure to respond to contact from the Provider when matters were eventually escalated. The Ombudsman was also concerned that information was not shared with Mrs X about Ms Y's condition or, at the very least, that Ms Y's consent was not sought to discuss concerns with Mrs X; she may have refused consent but attempts to seek it should have been made. These deficiencies in care amounted to a service failure. This was an injustice to Ms Y as she was denied earlier involvement by the Council to assess her support requirements and an injustice to Mrs X as Ms Y was not given the opportunity to consider whether she wanted to consent to Mrs X being consulted about her situation. The Ombudsman could not say that earlier interventions would have altered the sad outcome. Ms Y, an adult with capacity, may have continued to decline support/drink in excess even if these actions had been more robustly pursued. However, the Ombudsman was clear that several opportunities to intervene were lost.

The Ombudsman was also concerned about the way Mrs X's complaint was handled. Mrs X's complaint to the Council was investigated under the social services complaints procedure and an independent investigator ("the II") was appointed to investigate her complaint at stage 2 of this process. The II did not uphold Mrs X's complaint but shared a Management Note ("the Note") with the Council relating to issues about the Provider's handling of the situation which did not form part of the Stage 2 investigation conclusions; the Note was not shared with Mrs X.

The Note suggested that the II thought the Provider should have escalated the matter. The Ombudsman found that the Note findings ought to have been openly included and transparently analysed in the Stage 2 report and she was concerned that the Council did not share with Mrs X matters that were relevant and potentially critical of the Council's actions (taken on its behalf by the Provider) in an open manner. The Ombudsman found that, had the findings of the Note been included in the II's report, then the outcome of the II's investigation should have been different. This was maladministration resulting in a serious injustice to Mrs X, as she was

unaware of the Note findings. This also departed from the Ombudsman's guidance on the principles of openness and accountability which public bodies should adhere to.

The Ombudsman **upheld** Mrs X's complaint and made several recommendations to the Council; the Council agreed to implement these which were:

a) To provide a meaningful, written apology to Mrs X for the shortcomings identified in the Ombudsman's report.

b) To implement all the actions contained in the Note if it had not already done so.

c) To remind those it contracts to undertake independent investigations on its behalf to ensure that any findings/critique of the service provided to a client should be reflected in their report and findings and not shared separately with the authority.

d) To remind relevant staff of the importance of regular contract monitoring in relation to the delivery of social care services by third party providers to ensure appropriate intervention if there are concerns about the provision of service/a change in a client's needs.

The Complaint

1. My investigation considered whether Wrexham County Borough Council ("the Council") provided appropriate and adequate support to Mrs X's sister, Ms Y, in the months leading to her death, including whether information was shared appropriately between the Council and a third-party organisation providing services on behalf of the Council ("the Provider"), and whether the Council took appropriate action in relation to any information shared.

Investigation

2. I obtained comments and copies of relevant documents from the Council and considered those in conjunction with the evidence provided by Mrs X.

3. I also obtained advice from one of the Ombudsman's Professional Advisers, Paula Hendry, a social worker with 32 years of experience of adult social services ("the Adviser"). The Adviser was asked to consider whether, without the benefit of hindsight, the social services care had been appropriate in the situation complained about. I determine whether the standard of care was appropriate by making reference to relevant national standards or regulatory, professional or statutory guidance which applied at the time of the events complained about.

4. In cases involving the exercise of professional judgement in social care, I consider advice provided to me by professional social work advisers who consider whether the care delivered by a public body has been appropriate in the circumstances. In relation to events which span the height of the COVID-19 pandemic, I carefully consider whether the care delivered was appropriate within this context and take into account the severe pressure on public bodies at this time.

5. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

6. Both Mrs X and the Council were given the opportunity to see and comment on a draft of this report before the final version was issued.

Relevant documents

7. The Council entered into a contract with the Provider for the provision of supported living services: "Contract for the provision of supported living services between [the Council] and [the Provider] – 8 April 2019 to 7 April 2020" ("the Contract"). The service specification (at Appendix 1 of the Contract) includes the following provisions:

- The Provider shall determine the methods and procedures to use for ongoing monitoring and reviewing (2.2.2).

- The Provider must ensure staff have appropriate written guidance from which they make day-to-day decisions about the degree of independence and support appropriate for the service users (3.27).

- In terms of critical incidents, the Provider shall be responsible for notifying the Council immediately and confirm in writing within 24 hours if any of the following occur – any circumstance where the service users refuse provision of service (3.4.3); change to service users' mental or physical condition / well-being (3.4.4); any serious injury or illness of service users (3.4.8).

8. My office's "Principles of Good Administration" ("the Guidance") provides a framework for all public service providers to follow in fulfilling their duties. The principle of 'being open and accountable' includes "taking responsibility for your actions whether you are delivering the services yourself or through a third-party contract or commissioning arrangements". In doing so, bodies should handle information as transparently and as openly as the law allows and be "open and truthful when accounting for your decisions and actions" and "take responsibility for the actions of your staff and those of others who act as your agents".

9. The Welsh Government's "A guide to handling complaints and representations by local authority social services" (August 2014) ("the Complaints Guide") states that the Independent Investigator ("II") appointed to consider the complaint should be objective and as open as possible about their methods and about the reasons underlying their

conclusions. The II report should meet a number of tests and should, amongst other things, make recommendations for improving the service so that other service users do not have cause to make the same complaint.

Relevant background information and events

10. I have outlined key dates and events in this section. As the Adviser has referred to specific documentation/events in her advice (paragraphs 28 - 49), I have not repeated them here. Whilst I have not referenced each document received and considered, I confirm these have been reviewed in their entirety by both my Investigation Officer and the Adviser.

11. Mrs X explained that Ms Y lived with her since February **2014** and before that, with their mother who had been Ms Y's lifelong carer. In **2016** Mrs X approached Social Services with a view that Ms Y should lead a more independent life. She wrote to the Council's Community Learning Disability Team to relay key information about Ms Y before a series of assessments that would determine appropriate living accommodation for Ms Y. Mrs X said that she outlined that Ms Y would require 24-hour care and outlined the level of support that she would need. Mrs X said that she informed the Council that one of her main concerns was Ms Y's alcohol consumption which had been a long-standing problem. Following assessment, Ms Y was offered a flat in a brand-new Housing Association development ("the Flat").

12. On 9 April **2019** Ms Y moved into the Flat. The Council entered into the Contract with the Provider, to provide on-site daily care/support to 6 residents equating to 8.5 hours per day shared between the 6 residents. On 17 April **2020** Ms Y was found deceased in the Flat.

13. Mrs X complained to the Council on 3 July about the state that Ms Y was found in and the unacceptable state of her living conditions. Mrs X said that Ms Y was found in filthy clothing, had been sleeping in urine-soaked sheets, several carrier bags full of empty wine bottles were found, there was general rubbish around the rooms, soiled bedding/laundry in a cupboard, 40 messages on her answerphone (she said Ms Y did not know how to use it), 400 letters hidden in the Flat, and the bathroom was unhygienic.

14. Mrs X said that there were factors that indicated that Ms Y had not been receiving appropriate support and supervision. She noted the amount of chocolate and desserts in Ms Y's flat despite her being borderline diabetic. She also noted receipts showing that, despite lockdown, Ms Y continued to access shops most days, and there were receipts showing she had purchased over 40 bottles of wine in the weeks leading up to her death.

15. Mrs X said that when she approached the Council's Social Services Department in 2016 to discuss arrangements for Ms Y to live a more independent life (Ms Y wanted to have her own place), various supported living options were considered. Mrs X considered that the care package arranged for Ms Y at the Flat equated to a little more than an hour of care a day.

16. Mrs X said that from the day Ms Y moved into the Flat, Mrs X was not informed of, or invited to, any care reviews and she felt excluded. Mrs X said that an adequate care package was lacking from the outset and the lack of care and supervision contributed to Ms Y's early and tragic death.

17. The Council acknowledged Mrs X's complaint on 16 July and informed her that it had appointed an II to investigate her complaint at Stage 2 of the Social Services Complaints Procedure. The II met Mrs X and her husband on 3 August to establish the complaints for investigation. Mrs X raised several concerns, the majority of which related to the Council's agreement with the Provider and about the level of information sharing and support agreed between the Council and the Provider.

Mrs X's evidence

18. Mrs X said that Social Services failed to recognise the needs of Ms Y when she moved to independent living. She said the care package was "hugely insufficient" and she considered that Ms Y needed 24-hour care initially as this was the first time she had lived outside the family unit. Mrs X said she provided the Council with comprehensive background information about Ms Y and felt this was ignored.

19. Mrs X said Ms Y died suddenly and was found in a state of severe self-neglect. She was dissatisfied with the Council's response to her complaint, which was not upheld. Whilst the response said that a thorough investigation had taken place, she was of the opinion that there were still unanswered questions.

20. Mrs X did not consider that Ms Y was provided with an appropriate or adequate level of support. She said Ms Y was 1 of 6 vulnerable people who were allocated 8.5 hours of support per day between them and, therefore, Ms Y went from receiving 24-hour support to 1.4 hours per day. She also questioned the adequacy of the Council's initial assessment and support offered.

21. She said that the Council's response to the Stage 2 investigation indicated that there was sufficient documentation to show that Ms Y was well cared for and well looked after. Mrs X concluded that many of the records must have been fabricated or written in a way that showed that Ms Y received more support than she did. Mrs X suggested that the twice daily checks on Ms Y were "doorstep calls" and that staff did not enter the Flat regularly or that they did access her flat and ignored the poor state it was in.

22. Mrs X disagreed with several findings of the Stage 2 investigation and questioned aspects of Ms Y's care. She said that:

- Whilst the report said that the state of Ms Y's Flat was deemed wholly unsatisfactory, the evidence on file demonstrated that Ms Y's flat was not routinely in such a state. She disagreed, saying that the Flat was in a poor, unhygienic state and this had built up over a prolonged period; it had not got into such a state overnight.

- Whilst it was documented that Ms Y did not want Mrs X to be consulted regarding her views, Mrs X said she should have been advised of this so she could have discussed this with Ms Y. She said she was totally excluded from all parts of Ms Y's life, despite being given consent by Ms Y in her original care plan.

- Whilst there were several references to Ms Y having full capacity to make her own decisions, she did not believe that Ms Y had capacity around her own needs and was not able to weigh up the issues around excessive alcohol consumption and the consequences of that.

- The report stated that in the month leading up to Ms Y's death, her alcohol related issues had begun to reach a threshold whereby it would have been necessary to relay concerns to the Council's Social Services Department, but that due to Ms Y's untimely passing this did not occur. Mrs X questioned how bad the situation needed to reach to take this action. Mrs X said that, had the Council listened to her, Ms Y would probably still be alive.

- Whilst it stated that Ms Y was engaging positively with staff, it also said that she frequently declined support.

- Whilst the investigation said the Provider supported Ms Y on a regular basis with recurring issues, it also said that there were numerous documented occasions where Ms Y's Flat became untidy or unhygienic and that Ms Y declined more offers of support than she accepted.

The Council's evidence

23. The Stage 2 investigation did not uphold Mrs X's complaints. In summary, the II found:

- That Ms Y was deemed to have full capacity to make her own decisions.

- For the majority of the tenancy, the Provider provided support in line with Ms Y's support needs as identified by the Council.

- The Council carried out a general audit of the services being provided by the Provider in line with the contract agreement.

- During the month leading up to Ms Y's death, her alcohol related issues had begun to reach a threshold whereby it would have been necessary to relay concerns to the Council but, due to Ms Y's death, this did not occur.

- The Provider was provided with the Council's Care Assessments and Care Plan. The Provider produced risk assessments and recorded observations in a diary twice daily. Ms Y was discussed during Team Meetings and the Provider produced a Support Agreement with Ms Y's input and agreement.

24. The Council's formal response to the Stage 2 investigation (16 February 2021) confirmed it accepted the findings of the II's report in full. It said that despite the complaints not being upheld, the Council would address certain issues of how it worked in such projects in future to ensure early escalation of problems. It confirmed it had instructed the Service Manager for Social Care to progress this area of work.

25. The II shared a management note ("the Management Note") with the Council outside the investigation process for action by the Council's Social Services Department which was noted to be "internal – not part of published report or shared with the complainant". This Management Note was not therefore shared with Mrs X. The 4 findings of the Management Note were:

- **Finding 1** - There may be merit in the Council meeting with the Provider to reflect on what is deemed as the appropriate threshold for escalating a concern/referral back to the Council Social Services Department, especially in relation to a service user declining support.

- **Finding 2** - The Council may want to explore what action the Provider took when a member of support staff escalated concerns about Ms Y to managers.

- **Finding 3** - It was February 2020 (10 months into the tenancy) when the Provider determined that Ms Y needed a regular female support worker on a weekly basis to assist with personal care. This coincided with Ms Y's increased alcohol related behaviour.

- **Finding 4** – the Council may want to explore with the Provider whether support staff actively reported issues to 'on-call' relating to Ms Y being affected by alcohol. There were 3 references (see finding 2) to staff escalating or reporting issues to managers, but there were more than 10 entries relating to Ms Y being drunk or affected by alcohol.

26. The actions outlined in the Management Note stated that the Head of the Disability Service met the Contracts Team and Project Manager and that it seemed that the Contract was clear around agencies raising concerns, in particular section 3.4 (see paragraph 7). It was also noted that a further meeting had been arranged with the Provider on 27 April 2021 to discuss these concerns with it.

27. The Interim Head of Service, (Disability Service), sent an email to the Provider's Chief Executive Officer on 28 April following a meeting where they discussed the outcome of the investigation. She noted that although the complaints were not upheld, the II offered some 'management notes' for further review outside the investigation (as outlined above). Attached to the email was a copy of the Contract which highlighted sections relating to escalation of critical risks. She acknowledged that flexible support was key within the supported living environment. She noted that one of the key areas highlighted for improvement was around the escalation of critical incidents and during discussions some options were suggested. She offered assurance that the Social Services Department would offer support and advice as necessary around any concerns raised. She also encouraged the Provider staff to engage with this support "to ensure a multi-disciplinary approach is used when there are concerns around 'risk' to avoid decisions being made in isolation".

Professional Advice

28. The Adviser noted that soon after Ms Y moved into the Flat, there were concerns that she was drinking at least 1 bottle of wine a night and had bought 8 bottles of wine over a weekend (on 21 May 2019). Ms Y was documented to have told an Enablement Officer at the Council ("the Officer") that she had been drinking between 1 and 2 bottles of wine a night when living with Mrs X (without Mrs X's knowledge) and that she had reduced her alcohol intake since moving into the Flat.

29. The Adviser said Ms Y was spoken to about this and agreed she had an alcohol problem and agreed to support; the Social Worker would make a referral to the Learning Disabilities Team so Ms Y could access support from a psychologist/psychiatrist. Ms Y also agreed to a referral to substance misuse/alcohol services. In addition, the Provider put in place a new risk assessment and support plan for Ms Y's drinking and all staff were advised to keep a look out for wine bottles and glasses and report if seen.

30. The Adviser noted the referral to substance misuse services was made but Ms Y did not attend; it was unclear whether the refusal to attend was explored further with Ms Y to persuade her to accept help. It was also unclear if the alcohol issues and referrals for support were discussed with Mrs X, who was concerned about Ms Y's welfare and may have been able to help persuade Ms Y to seek support.

31. The Adviser said that the appointment with the Learning Disability Team to address Ms Y's drinking was made, but Ms Y did not attend. When a social worker discussed this with Ms Y, she declined any support. The refusal to attend this appointment and the substance misuse services should have been discussed with Ms Y and Mrs X. The Adviser said that the social worker recognised that Ms Y would inevitably need some support to address this, given her lengthy history of drinking alcohol, and that it would have been very difficult for Ms Y to reduce her drinking without support. The Adviser acknowledged that attempts to persuade Ms Y to accept support may not have been successful but said it should have been tried.

32. In terms of consulting with Mrs X, the Adviser noted that the Stage 2 report referred to it being "documented" that Ms Y stated to the Council/the Provider that she did not want Mrs X to be consulted in relation to her "reviews". The Adviser said that this was briefly mentioned on file, but specifically in relation to the 1 review that was carried out. She said that this 1 instance of Ms Y not wanting Mrs X at a review did not necessarily rule out ongoing liaison and exchange of information with Mrs X outside of the review, and Mrs X was contacted about other matters. The Adviser said that Ms Y should have been asked for her consent for these matters to be discussed with Mrs X. She may have refused consent to speak to Mrs X about her drinking, but the Adviser said she should have been asked; Mrs X might have been able to persuade Ms Y to accept support.

33. The Adviser noted that, in August 2019, Ms Y was spoken to about accepting support with her daily living tasks but she said she could do these herself. There were concerns about her being unkempt and how she could be helped with this as she had been refusing help. The Adviser noted this became an ongoing concern with staff struggling to persuade Ms Y to accept support at times. The Adviser said it was difficult to evaluate how often Ms Y was accepting support; the Stage 2 investigation did not provide a firm evaluation but suggested that acceptance was ad hoc, and that Ms Y declined more support than she accepted.

34. Whilst Ms Y appeared to have capacity and therefore could decide if she wanted to accept support, the Adviser said that she had been placed at the Flat with a care package of support that was deemed to be appropriate to meet Ms Y's assessed needs. If Ms Y was refusing support more than she accepted it, the Adviser said the Council should have been made aware. It could then have considered if the support setting was right for Ms Y and whether she required further work with the Officer or if other services were necessary or if she might engage more fully in a more structured and highly supported setting. The Adviser said that, overall, there appeared to be something of a problem, and consideration should have been given to what it was and how it could be addressed. The Adviser was not clear that the Council was made aware of the issues about Ms Y not accepting support at this point in time (August 2019).

35. The Adviser noted that by September/October 2019, concerns were noted that Ms Y was on the landing a lot and that she might be watching for staff to leave so that she could have a glass of wine. The Provider staff were told to continue to monitor Ms Y. There was no evidence that the Provider discussed this concern with Mrs X or the Council. Ms Y was also continuing to decline support on a fairly regular basis at this time.

36. During this time, there was also a focus on Ms Y's financial matters which was resolved in liaison with Mrs X, her appointee. It was noted that a social worker, in conjunction with Ms Y and the Provider staff were going to create a system of supporting Ms Y with her mail. It was unclear however if the system was set up or if Ms Y did not comply with it. Mrs X found a number of unopened letters in the Flat following Ms Y's death which suggested the system might not have been put in place. If the

system had been initiated and Ms Y was non-compliant with it, the Adviser said the Provider ought to have referred the matter back to the Council as there was a risk that important paperwork would go astray; Ms Y's inability to manage her financial paperwork was the reason why the appointeeship was needed.

37. By November 2019, the Adviser said there was a mixed picture. She said some concerns began to mount about Ms Y's drinking but at other times, there was nothing to suggest she was drinking and Ms Y's engagement with support was variable but on occasion, she did accept support. However, on 30 November, Ms Y was found with 2 and a half empty bottles of wine by her chair and was unsteady on her feet and, on 8 December, staff thought that Ms Y was drunk and she was struggling to stand up straight. The Adviser said the case was still open to the Council at that time but there was nothing to suggest that either the Council or Mrs X were made aware of the increasing concerns.

38. The Adviser said the same was true of the period following New Year when it was noted that Ms Y had been drinking quite a lot (she was said to be very drunk on 19 January 2020). Whilst Ms Y had capacity, the Adviser said her alcohol use was known to have been problematic and she said this would have been a good point to escalate matters to the Council and her family with a view to attempting to persuade Ms Y to accept support (e.g., substance misuse services, psychiatry, or psychology).

39. By January 2020, the Adviser noted that Ms Y was seemingly refusing staff support a great deal; on 22 January Ms Y's bedroom did not appear to have been cleaned for a couple of weeks and, on 31 January, there was lots of washing found hidden behind the door and her fridge had to be cleaned and her flat "sorted". The Adviser noted that it was documented that Ms Y had been spoken to on several occasions and was in breach of her tenancy (due to not accepting support), but the matter was not escalated to the Council.

40. The Adviser noted that matters appeared to have settled down a bit in early February but on 26 February, the Flat was "in a mess again" when the door was opened by staff after Ms Y had refused to open it. Ms Y was

told there was a serious problem on 2 March and that it would be escalated to the Council. The Adviser said there were several more incidents over the next week, but the matter was still not escalated to the Council.

41. The Adviser noted that on 23 March, wine was seen in the Flat. She also noted that Ms Y allowed staff to clean her bedroom and bathroom; Ms Y was noted to be drinking cider a few days later. The Adviser noted that the Provider then attempted to escalate matters. The Adviser said she was "highly confused" by the content of the Stage 2 report which suggested that the matter did not reach the threshold for being passed on to the Council before Ms Y died. The Adviser commented that the Contract clearly set out the circumstances in which matters should have been escalated and there was plenty of opportunity for this to have happened before Ms Y died. She noted there were concerns about Ms Y accepting support from August 2019 onwards and it was unclear if Ms Y ever accepted help with her financial paperwork. In addition, by 30 November 2019, it was "very apparent" that Ms Y was drinking to the point of potentially being unsafe. The Adviser said these were times when the Council ought to have been informed of the concerns.

42. Further, the Adviser noted that the Provider Team Leader at the Flat Complex ("the Team Leader") made several attempts to pass the matter on to the Council in March and April but had not been able to contact anyone. She said this raised a question for the Council as to why the Team Leader could not obtain help and support during this period; the Adviser said she was aware this was a difficult time for local authorities (due to COVID-19) but that the Team Leader ought to have been able to make contact with someone for immediate advice. The Adviser was also of the view that Mrs X should have been alerted to Ms Y's deterioration as her next of kin.

43. The Adviser noted that the II shared management notes with the Council and said this was rather "puzzling". She said that, whilst the Stage 2 investigation appeared to absolve the Provider from any responsibility by suggesting Ms Y died before the concerns could have been escalated, the Management Note appeared to imply that, in fact, the II thought that the Provider ought to have escalated the matter. The Adviser was satisfied that the contractual arrangement was clear enough in this regard around

escalation. The Management Note appeared to cover various issues concerning the Provider's handling of the situation. The Adviser said the apparent attempts of the Provider staff to escalate the matter, albeit rather late on, and the Council's seeming lack of response, do not appear to have come to light at all during the Stage 2 investigation.

44. If Ms Y would not engage with staff support for personal care, care of her home and management of her paperwork, the Adviser said this should have been escalated to the Council as soon as Ms Y's non-engagement was identified so that her care plan review could be brought forward, and any necessary adjustments/additional support could be considered. The Contract stated that the Provider had responsibility for organising service reviews every 6 months or more often if necessary; the Adviser said, in considering Ms Y's non-compliance, the Provider could and should have used this mechanism to alert the Council to its concerns.

45. The Adviser said that it did not seem that the Provider staff communicated concerns to the Council as they occurred or that they initiated reviews as per the terms of the Contract when there were concerns. The Adviser said this called into question whether the Provider had fulfilled its responsibility to make appropriate written guidance available to staff as it seemed there was confusion at times for staff in achieving a balance between avoiding restricting Ms Y's independence and supporting her safety and welfare. As a result of this, the Adviser said the Provider did not fulfil the responsibilities set out in the Contract (see paragraph 7). In particular, the Adviser noted there appeared to have been hesitation on the part of Provider staff in February and March 2020 before Ms Y's death, when incidents were occurring fairly regularly, but the Council was not informed. The Adviser also noted that attempts were made to contact the Council but that no-one could be contacted. The Adviser said the Stage 2 report was unhelpful in this regard as it only served to confuse the matter by not mentioning these failed attempts.

46. In terms of Mrs X's complaint that, at the time of Ms Y's death, she was found in a state of neglect and her dignity had not been maintained, the Adviser said that it was possible that some of the conditions found by Mrs X had existed for some time and were hidden from staff, while other issues had arisen more recently. Unfortunately, these questions would

never be answered. However, the Adviser said a more robust analysis at Stage 2 in marrying up the Provider records and staff accounts would have been helpful to try and understand how the Flat could have come to be in such a state by the time of Ms Y's death.

47. The Adviser said that, if the Flat was found in the condition described, and the Council and family were not alerted and then the Council was alerted, and did not respond, these were failures. However, if Ms Y was determined to drink and refuse support, there may have ultimately been nothing that could have been done. That said, attempts should have been made to offer help with these issues and to initiate a review of Ms Y's needs and possibly a reassessment by the Council.

48. As a vulnerable adult with a history of known alcohol dependence, the Adviser said that these matters should have been escalated sooner and that the Provider should have been able to access help from the Council when matters were finally escalated. In summary the Adviser said there were deficits in:

- The Council's initial approach to Ms Y's drinking problem which should have been pursued with her more robustly and ought to have been discussed with Mrs X with Ms Y's consent.

- The Provider's approach to the management of Ms Y's paperwork, her drinking and her refusals of support, all of which ought to have been escalated as and when concerns arose, which would have been in accordance with the contractual provisions in place.

- The Council's response when the Provider seemingly attempted to escalate matters.

49. However, the Adviser said that it was entirely possible that even if these things had been done, Ms Y might have continued to decline support at times and to drink, even if she was in a more supported setting. If more attempts had been made and if Mrs X had been liaised with more closely over the concerns, Mrs X would at least have had the assurance that all efforts had been made to assist Ms Y.

Comments on the draft report

50. Mrs X said that "to learn that the 'management note' did not form part of the [Council's] response has astounded me". She said that the Council's response to the Stage 2 investigation stated that "I hope this report provides you with the answers you were seeking" and confirmed that none of the 8 elements of her complaint had been upheld. Mrs X said that she could not "begin to explain how hurtful this had been to receive at the time" and made her feel as though she had complained about an insignificant matter; she did not feel that she had received answers. She felt that my investigation finally provided answers to her complaint.

51. Mrs X said that she respected everyone's right to privacy and whilst her sister may have declined for her to be informed about how things were going, she said that for her sister not to be asked, did not provide either of them with the opportunity to discuss and put things right together. She said they had a very close relationship and Mrs X felt she could have persuaded her sister and supported her to access help had she been aware of the problems.

52. The Provider's comments to the Council on the findings outlined in my draft report which were shared with me; I am satisfied that the Council said it would engage with the Provider through its contracting process to address the issues highlighted in my report.

Analysis and conclusions

53. In reaching my decision, I have been guided by the advice I have received, however the conclusions I have reached are mine. I would like to extend my sincerest condolences to Mrs X and the family for the sad loss of Ms Y.

54. The Council was aware that Ms Y had an alcohol problem; Mrs X had explained to the Council in 2016 that one of her main concerns was Ms Y's alcohol consumption which had been a long-standing problem. A referral was made to substance misuse services and the social worker agreed to refer Ms Y to the Learning Disabilities Team to access support from the

Team's psychologist/psychiatrist. As it was acknowledged that Ms Y would need support to address her drinking, these referrals were appropriate and recognised that Ms Y would need support to help reduce her alcohol consumption.

55. However, I am concerned that despite failing to attend for her referral at the substance misuse service, it does not appear that this was explored further with Ms Y or that the Council contacted Mrs X to see if she was able to persuade Ms Y to seek support. I do not consider that Ms Y's refusal for Mrs X to be consulted in relation to her "reviews" was necessarily a blanket refusal for Mrs X to be consulted on every aspect of her care. As a minimum, it would have been good practice to have asked Ms Y for her consent to discuss matters with Mrs X and her decision to decline support from the Learning Disability Team and substance misuse service; while she may have refused consent, she should have been given the option.

56. It is apparent that whilst there were mounting concerns about Ms Y in terms of her regular refusal of support (although she did accept support at times), about the state of Ms Y and her flat, and around her drinking (see the advice section above for details of incidents), the Provider did not escalate these to the Council until March 2020. There were several examples of when Ms Y's refused provision of service and where there was a change to her mental or physical condition; the Contract clearly sets out the circumstances in which matters should have been escalated to the Council and includes such instances.

57. Whilst the Provider was under contract to provide services on behalf of the Council, the Council remained responsible for the delivery of the services to Ms Y. The Council should have ensured it monitored the delivery of this service to make sure it met Ms Y's needs as outlined in her care package. I accept the advice that the threshold for raising concerns with the Council had been met several weeks before March 2020 and that the Provider did not share relevant information with the Council and Mrs X; this was a failing. Even when it was documented that Ms Y had been spoken to on several occasions and was told she was in breach of her tenancy for not accepting support, the matter was still not escalated to the Council. Had it been, given that Ms Y had been placed in the Flat with a care package that was assessed as appropriate to meet her needs, the

Council could have considered whether the support setting was right for Ms Y given that Ms Y appeared to be regularly declining support. Also, it could have consulted with Mrs X about the situation and considered if there was a more suitable setting for her needs. There was also the option, in line with the Contract, to arrange a service review sooner than the stipulated 6-month period if necessary.

58. Given the concerns documented by the Provider, it could have initiated an earlier review which may have led to the sharing of information with the Council sooner. Whilst I agree with the Adviser that it may have been that staff were trying to achieve a balance between avoiding an overly restrictive intervention in Ms Y's independence against supporting her safety and welfare, there were sufficient concerns about Ms Y that should have led to their escalation. I should also recognise that when Ms Y died, the COVID-19 pandemic had already placed severe pressure on the Council and the Provider's services for some 6 to 8 weeks which will have affected service delivery at that time. However even taking that into account and recognising the circumstances under which the Council was operating and the demands on its services at the time, the failings in this case were significant and, as such, I consider that they amount to maladministration. Additionally, as highlighted in this report there were many missed opportunities to escalate Ms Y's care and support needs to the Council before the COVID-19 pandemic struck.

59. I am also perplexed by the Stage 2 report in suggesting that matters had not reached the threshold for being passed on to the Council before Ms Y died. Having taken into account the advice, I agree that there were sufficient concerns that would have justified reporting these to the Council and would have been in line with the Provider's contractual obligation to do so. In fact, the evidence suggests, albeit belatedly, that the Provider tried to contact the Council (in March 2020) to raise concerns which implies that the Provider deemed that matters had reached the threshold, something the II failed to identify in the Stage 2 report.

60. What I also find concerning is that the II did not uphold Mrs X's complaint but shared the Management Note with the Council. This clearly did not form part of the Stage 2 investigation conclusions, but it did relate to issues about the Provider's handling of the situation; these notes were not

shared with Mrs X. Therefore, whilst the II appeared to absolve the Provider from any responsibility in their report by suggesting Ms Y died before the concerns could have been escalated, the Management Note suggested that the II thought the Provider should have escalated the matter. This accords with my Professional Adviser's view and this information should have been included in the II's investigation and formed part of the analysis by the II. The failure to do so calls into question the robustness of the investigation and I do not, therefore, consider that the Stage 2 investigation or its findings are sound. The lack of transparency with Mrs X was unjust and goes against the requirements laid out in the Complaints Guide; this also amounts to maladministration.

61. The Management Note findings ought to have been openly included and transparently analysed in the Stage 2 report. Mrs X was unaware of the existence of the Management Note. Whilst the Council's response to the Stage 2 investigation confirmed it would address certain issues of how it worked to ensure early escalation of problems, this did not provide a transparent picture of what was shared by the II.

62. Whilst no specific complaint was made by Mrs X about the Stage 2 investigation process, given that she was unaware of the Management Note, and that she was dissatisfied generally with the way in which the Council handled her complaint and considered that unanswered questions remained, it is appropriate for me to comment on this matter. I am concerned that the Council did not share with Mrs X matters that were relevant and potentially critical of its actions (taken on its behalf by the Provider) in an open manner. In this case I consider that, if the findings of the Management Note that were omitted from the Stage 2 investigation had been included in the II's report, then the outcome of the II's investigation should have been different. This is a serious injustice to Mrs X and departs from the Guidance and principles of openness and accountability which public bodies should adhere to.

63. The Provider did not attempt to contact the Council until March 2020 about its concerns relating to Ms Y. However, when the Team Leader made several attempts to contact the Council in March and April 2020, he was unable to get hold of anyone. This period marked the beginning of the COVID-19 lockdown and local authorities, and other public bodies were having to make adjustments to services to manage the impact of the

situation. However, the Team Leader should have been able to access help/advice from the Council at some point over this period and it was unclear why he was unable to. I am also concerned that Mrs X was not advised of Ms Y's deterioration. It would have been entirely reasonable to have sought Ms Y's consent to discuss concerns with Mrs X; Ms Y may have refused, but as above, attempts to seek consent should have been made.

64. Given the description given by Mrs X about the state of the Flat when Ms Y was found, it is understandable that she would question whether Ms Y's dignity was maintained. It is possible that Ms Y managed to hide the condition of the Flat from Provider staff, or that some of the issues had arisen more recently; there is evidence that Ms Y allowed staff to clean her bedroom and bathroom on 23 March. I do not consider that I can reach a definitive conclusion on this issue.

65. Based on the available information, I am satisfied that there were several failings in Ms Y's case which amount to maladministration, namely the Council's management of its approach to Ms Y's drinking problem, the failure by the Provider to escalate matters to the Council in accordance with the terms of the Contract, and when concerns arose about Ms Y, the Council's failure to respond to contact from the Provider when matters were eventually escalated.

66. I am also concerned that information was not shared with Mrs X about Ms Y's condition or, at the very least, that Ms Y's consent was not sought to discuss concerns with Mrs X. These deficiencies in care amount to a service failure by both the Council and the Provider. Whilst many of the failings were on the part of the Provider, as the body with overall responsibility for the delivery of its social care functions, the Council remains responsible for the failings. Ms Y was a vulnerable adult and more could have been done by the Provider to access help/support from the Council at an earlier stage had information been shared with the Council and if the Council responded to the Provider's contact in March and April 2020 for assistance. This was an injustice to Ms Y as she was denied earlier involvement by the Council to assess her support requirements. It was also an injustice to Mrs X as Ms Y was not given the opportunity to consider whether she wanted to consent to Mrs X being consulted about her situation. I **uphold** the complaint. I cannot say these earlier interventions would have

altered the sad outcome. Ms Y, an adult with capacity, may have continued to decline support/drink in excess even if these actions had been more robustly pursued. However, I am clear that several opportunities to intervene were lost.

Recommendations

67. I **recommend** that, within **6 weeks** of the date of this report, the Council:

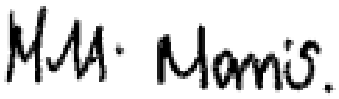
a) Provides a meaningful, written apology to Mrs X for the shortcomings identified in this report.

b) If it has not done so already, implements all the actions contained in the Management Note.

c) Reminds those it contracts to undertake independent investigations on its behalf to ensure that any findings/critique of the service provided to a client should be reflected in their report and findings and not shared separately with the authority.

d) Reminds relevant staff of the importance of regular contract monitoring in relation to the delivery of social care services by third party providers to ensure appropriate intervention if there are concerns about the provision of service/a change in a client's needs.

68. I am pleased to note that in commenting on the draft of this report the Council has agreed to implement these recommendations.



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