Local Government &
Social Care
OMBUDSMAN

Report by the Local Government and Social Care Ombudsman

Investigation into a complaint against Tameside Metropolitan Borough Council (reference number: 17 012 757)

3 April 2018

Local Government and Social Care Ombudsman
www.lgo.org.uk

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

Mrs C	The complainant
Ms J	Her granddaughter and representative
Mrs H	Mrs C’s daughter, and Ms J’s mother

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Report summary

Adult care services

Ms J complains about the actions of a care home at the time of the death of her grandmother, Mrs C, whose placement there had been commissioned by the Council. She also complains about the Council's handling of her concerns after Mrs C's death.

Finding

Fault found, causing injustice, and recommendations made.

Recommendations

We recommend the Council should:

- pay Ms J £1500 to recognise the distress she and her family has suffered;
- ensure that it has published clear guidance for care home staff on when to notify next of kin, in the event of a resident's deterioration in health;
- ensure that it has published clear guidance for care home staff on when to seek medical advice, in the event of a resident's deterioration in health, and especially where there is a possibility of contagion;
- share this report with staff at Oakwood Care Centre; and
- ensure that all relevant staff have a clear understanding of how to handle safeguarding concerns.

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)***

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The complaint

1. The complainant, to whom we will refer as Ms J, represents her late grandmother, to whom we will refer as Mrs C. Mrs C passed away in Oakwood Care Centre in April 2016, and Ms J complains about the way this was handled by the care home.
2. Specifically, Ms J says that:
   - Oakwood did not inform the family that Mrs C's condition was deteriorating, and did not make serious efforts to inform them that she had died. This meant that the news was broken to them by the police;
   - Oakwood showed a lack of urgency in seeking medical advice while Mrs C was deteriorating, and failed to ask a visiting GP to examine her;
   - carers performed cardio-pulmonary resuscitation (CPR) on Mrs C, despite the existence of 'do not attempt CPR' instruction;
   - Mrs C's end-of-life care plan was not followed, which meant that carers moved her downstairs to the lounge just before she died, rather than making her comfortable in bed;
   - the family raised safeguarding concerns with the Oakwood immediately after Mrs C's death, relating to observations they had made at the care home over several months, but they were treated as a normal complaint;
   - Oakwood has lost important records; and
   - that the Council's complaint handling was generally poor.

Legal and administrative powers

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 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)***
5. We cannot investigate late complaints unless we decide there are good reasons. Late complaints are when someone takes more than 12 months to complain to us about something a council has done. ***(Local Government Act 1974, sections 26B and 34D, as amended)***
6. 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 actions of Oakwood Care Centre, we have made recommendations to the Council.

How we considered this complaint

7. We have produced this report following the examination of relevant files and documents.

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Findings

8. Mrs C entered Oakwood in March 2012, and became a permanent resident in June 2012. Her placement there was commissioned by the Council, and so the care home constituted a contracted service.
9. On 26 January 2015, a 'do not attempt CPR' instruction was agreed with Mrs C's GP. In June 2015, the Council undertook an assessment of her care needs, which involved Mrs C's daughter (Ms J's mother), Mrs H, who is a nurse. The assessment determined that Mrs C's needs were being met at that time, and a reassessment was scheduled in a year's time.
10. On 17 April 2016, Mrs C's family visited her at Oakwood. She was well at this point.
11. But on 18 April, Mrs C's condition began to deteriorate rapidly. She stopped eating and drinking, began to vomit frequently and was suffering diarrhoea.
12. In the evening of 19 April, a carer called the out-of-hours GP for advice. The carer advised that Mrs C had a 'do not attempt CPR' instruction and an end-of-life care plan in place. The GP asked the carer to wait for a call back with further advice.
13. The GP called back and said that, due to Mrs C's 'do not attempt CPR' instruction, there was little they could do, but told Oakwood to call again if Mrs C became "restless" and they would visit.
14. At this point, the carers recorded that Mrs C had vomited in bed and that her breathing had become rapid. They decided to move her downstairs to the lounge so they could monitor her.
15. At approximately 12.35am on 20 April, Mrs C stopped breathing. Oakwood called an ambulance. When the ambulance arrived, the paramedics confirmed that she had died.
16. Oakwood called Mrs H on her mobile to inform her of the situation. Mrs H missed this call. It is disputed whether this call was shortly before, or shortly after, Mrs C died.
17. The police attended Oakwood to take statements shortly after Mrs C died. The police then broke the news of her death to Mrs H.
18. Mrs H wrote a letter of complaint to Oakwood on 24 May, and informed the Council that she had done so. The manager of the care home responded initially on 10 June, and then more formally on 25 July.
19. Ms J complained to the Council in March 2017. She included a list of safeguarding concerns in her letter.
20. The Council responded at Stage 1 on 21 July. It explained that there were various records missing from Oakwood, and that the care staff involved had since left post. It upheld some of Ms J's complaint, and explained that it undertaken Safe and Wellbeing checks on the residents at the care home.
21. Ms J requested a Stage 2 response in August. The Council responded on 20 October. It upheld further elements of the complaint, and confirmed that Oakwood's record-keeping had now been referred to the Care Quality Commission (CQC).

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Analysis

22. There are several different aspects to the complaint, which we will address in turn.

Communication with family

23. Ms J says that she and other family members visited Mrs C at Oakwood on 17 April. The carers did not inform them of any concerns about Mrs C's condition at this point, and made no attempt to contact the family again until the failed call to Mrs H's mobile, by which point Ms J says that Mrs C had already died. The police informed the family of Mrs C's death, which was the first they knew about her deterioration.

24. Oakwood's day diary records that Mrs C was visited by family members on 16 April. It also says that Mrs C had "visitors" (whom it does not identify) on 17 April. It is not clear whether there is confusion in the date which Ms J visited, or that different family members visited on each day.

25. However, it is clear from the day diary that Mrs C had not yet showed any signs of deterioration on 16 or 17 April. We have reviewed the diary from 19 March, and there is no significant difference in the description of Mrs C's condition each day until 18 April. There does not appear to have been any reason for the carers to have raised concerns with the family during their visit(s).

26. Mrs C's rapid deterioration began on the morning of 18 April. It is recorded in the diary that she vomited twice during the day, and three times overnight, although she apparently still ate and drank well through the day.

27. The night diary for 18/19 April also records that Mrs C's vomit was "black-brown".

28. On the morning of 19 April, the diary describes Mrs C as "confused and un-cooperative". She apparently ate and drank well during the early part of the day, but did not look or feel well. In the afternoon and evening, it was recorded that Mrs C had remained in bed, had not eaten or drunk and was suffering diarrhoea and vomiting.

29. There is an element of professional judgement for care staff in deciding when to notify family members that a person has become unwell. We would not criticise carers for failing to advise of every small change in a person's condition.

30. But Mrs C's frequent vomiting through the day and night of 18/19 April, and the fact that it was apparently 'black-brown', should have been indicators to the carers that she was seriously unwell. We consider that the family should have been notified of this by the morning of 19 April at the latest, which would have given them a reasonable opportunity to attend the care home, and see Mrs C before she died.

31. There is a dispute about the exact timing of the call to Mrs H's mobile, and on the evidence available, we cannot say whether it was shortly before or after Mrs C's death. But either way, we do not consider it to have been appropriate to wait this long to attempt to contact the family.

32. It is unfortunate that Mrs H missed this call, which was due to her phone being muted. The night diary records that, after Mrs C died, the police attended Oakwood to take statements. It appears that this is why the death notification came from them, rather than the care home.

33. We cannot say it was wrong for Oakwood to have failed to continue in its efforts to contact them after the police arrived. But even accepting this, the family should

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have been notified of Mrs C's deterioration much earlier. Had this happened, they would have had the opportunity to be at Oakwood with Mrs C when she passed away, and the police would not have needed to notify them.

34. The Council has acknowledged that the family should have been notified sooner of Mrs C's deterioration. It apologised in its Stage 2 response for the failure to do so.

35. While we welcome the Council's apology, the family was denied an opportunity to say goodbye to Mrs C, and it is clear that this has caused them significant distress.

Lack of urgency in seeking medical advice

36. Ms J says Oakwood waited until 10pm on 19 April before contacting the out-of-hours GP. She also says that a GP from Mrs C's surgery visited Oakwood coincidentally during the day of 19 April, but the carers did not ask him to examine Mrs C or give him any indication that she was unwell.

37. As a result of the lack of medical assistance, no cause of death could be established, which meant that a post-mortem had to be conducted, despite the family's express wish for this to be avoided.

38. The day diary notes that the out-of-hours GP said they would call back "within the hour (9pm)", indicating that the carer had called at approximately 8pm. The GP called back at 10.45pm. Ms J believes the carers did not call until approximately 10pm, but it appears possible that this is due to confusion over the fact that the GP called Oakwood back.

39. In either case, there is no record that Oakwood sought medical advice before 8pm on the evening of 19 April. This is despite noting early on 18 April that Mrs C appeared unwell, and despite the events of the night of 18/19 April, where Mrs C vomited several times and it was described as 'black-brown'.

40. Ms J says that, during the day of 19 April, a GP from Mrs C's surgery visited Oakwood to see another resident. The GP was not notified of Mrs C's deterioration.

41. The Council says there is nothing in the Oakwood's records to indicate that a GP visited on 19 April, but agreed that it would have been a good opportunity to gain some medical advice about Mrs C if this had happened.

42. Ms J has provided us with a copy of Mrs C's medical notes from the GP's surgery. There are two entries from a GP on 20 April. First:

"So sorry to hear that [Mrs C] passed away. I saw her yesterday in the lounge having her lunch, when I was visiting Oakwood. I was not informed of any concerns, but she did not look unwell."

43. And, later:

"I spoke to [name] from the Coroner's office … I explained to [name] that family do not wish to proceed with a post mortem; however, [name] informs me that, as there is no established cause of death, this may be unavoidable."

44. It is therefore accurate that a GP visited Oakwood on 19 April. It is concerning that the home could not confirm this.

45. Mrs C's 'do not attempt CPR' instruction and care plan cannot be located by Oakwood, and so we cannot say exactly what medical intervention would have

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been appropriate at this point. It may be that the most which could have been done for her would be to help make her comfortable.

46. Even accepting this, though, we agree that the Oakwood should have sought medical advice sooner than it did. Apart from Mrs C's own wellbeing, there was a possible health risk to other residents and to staff, given the apparent lack of explanation for her sudden symptoms.

47. Oakwood also missed an obvious opportunity to have Mrs C examined by the GP. This is especially so, when considering that he actually saw her during his visit.

48. Ms J says that the failure to seek medical advice directly contributed to the fact that a post-mortem was required.

49. When a death is reported to a Coroner, the role of the Coroner is to:

   - decide whether the cause of death is clear;
   - if not, request a post-mortem to find out how the person died; and
   - after the post-mortem, hold an inquest if the cause of death is still unknown, or if the person possibly died a violent or unnatural death, or died in prison or police custody.

50. It is evident that Mrs C underwent a post-mortem because her cause of death was not clear. But it would be speculative to say that earlier medical advice, or an examination by the GP during his visit, would have prevented the need for a post-mortem. It is possible that her symptoms might have remained unexplained, even after examination by a doctor, and that the post-mortem would still have been necessary.

51. We appreciate that the need for a post-mortem caused additional distress to Ms J and the family, and we do not seek to minimise this. But on the evidence available, we cannot say that it was because of fault by Oakwood.

52. But, even putting this to one side, there is significant fault in the care home's failure to seek medical advice earlier.

53. The Council has told us that, since Mrs C's passing, it has undertaken work to improve communication between care homes and GPs. It says that there is now greater integration between the Council and local NHS Trust, and that it has introduced technology to care homes, including Mrs C's, to allow staff to contact hospitals via Skype (internet video calling) to gain advice.

54. These are positive steps. However, in this case, the issue appears to relate more to how care home staff assessed the need to seek medical advice, not that they experienced obstacles in obtaining it. This is highlighted by the failure to consult the GP during his visit.

55. For this reason, the Council should demonstrate what guidelines there are for care staff to follow in determining whether to seek medical advice, and that there are safeguards in place to ensure that the guidelines are being followed.

Attempt at CPR

56. When Ms J originally complained to the Council, Oakwood's night records could not be located. At that time, the Council said there was no evidence that CPR had been performed.

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57. However, the night diary has now been located. There is an entry which is hand-written, but appears to read:

"[Mrs C] was sat in a wheelchair [at time of death]. Paramedic asked for her DNR. It was dated February 2015. She said it was out of date so start CPR. In the meantime [illegible] *paramedics turned up and said it was OK to stop CPR, as they have changed and no longer last 72hrs and that they* [sic] *are no on going DNRs."*

58. This entry is confusing and contradictory. The staff employed by Oakwood at the time of Mrs C's death are no longer in post, and so it is not possible to clarify it with them.

59. But we are satisfied that it demonstrates that CPR was attempted on Mrs C after the 999 call was made.

60. It is difficult to understand the reason for this. It is clear that the carer told the 999 call operator that there was a 'do not attempt CPR' instruction in place. It also appears that the out-of-hours GP was given this information.

61. The diary entry indicates that it was a paramedic who told the carers to attempt CPR. But it also suggests that this was before the arrival of paramedics, who then told the carers to stop.

62. It may be that there were two sets of paramedics, one arriving earlier than others. Or it may be because Oakwood received a call from the paramedics while en route. The poor quality of the entry means that this is unclear.

63. There also appears to have been some confusion over the validity of Mrs C's 'do not attempt CPR' instruction. Without being able to examine the document, we cannot determine the reasons for this.

64. We have also reviewed the paramedics' report. It gives no indication that CPR was attempted, nor does it shed any light on why the care home was instructed to do so.

65. The only thing which we can say with some certainty is that the staff attempted CPR because of an instruction from a paramedic.

66. In isolation, we would not criticise the staff for this. They had made it clear when summoning the paramedics that there was a 'do not attempt CPR' instruction in place, but it appears they then received an instruction to start CPR anyway. While we cannot determine why the paramedic gave this instruction, we would not consider it appropriate for staff to question the paramedic's judgement, especially in a life-or-death situation.

67. It may be that the paramedic made an error of judgement. If so, this would fall outside of the Ombudsman's jurisdiction. Alternatively, it may be that the details of the 'do not attempt CPR' instruction were communicated wrongly to the paramedic. If so, this may be the care home's fault, but since it cannot now be located, we are unable to draw a conclusion on this.

68. The poor record-keeping by Oakwood forms a separate element of this complaint, which we will address at a later point in this statement. But with regard specifically to the fact that CPR was attempted, the evidence indicates that the staff were following the advice of a paramedic, and, in isolation, we do not consider this to be fault.

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Failure to follow care plan

69. Ms J says that Oakwood failed to follow Mrs C's end-of-life care plan, by moving her downstairs from her bedroom to the lounge, where she died.

70. We can see from the night diary that staff decided to take Mrs C downstairs at approximately 11pm on 19 April, "in her best interests [and] to keep an eye on her". The diary then indicates that Mrs C passed away in a wheelchair.

71. As stated, we do not have a copy of the care plan, and so we cannot independently verify whether the decision to move Mrs C contravened the plan. But we accept that it appears to have meant that she died in less comfortable circumstances than if she had been allowed to remain in her bed.

72. Putting the specifics of the care plan to one side though, we are concerned about the staff's reasoning for moving Mrs C.

73. The staff wrote that it was in Mrs C's "best interests" for her to move downstairs, but entirely failed to elaborate on this. There is certainly no obvious reason why it would be in Mrs C's best interests to move from her bed, to a wheelchair in the lounge, when she was obviously very unwell.

74. There is also no indication of how staff moved Mrs C downstairs, which in itself was potentially risky, given her condition.

75. The staff recorded that they moved Mrs C to the lounge so they could monitor her. It is not clear why she could not be successfully monitored in her room, unless it was to allow staff to undertake other duties at the same time.

76. We appreciate that care home staff may have conflicting responsibilities at any one time. But we note that, during the conversation with the GP, Mrs C's 'do not attempt CPR' instruction, and the limitations this placed on medical intervention, were discussed. This suggests strongly that the staff considered that Mrs C was likely to be approaching death.

77. Given this fact, we consider that it would have been more appropriate for at least one member of staff to be dedicated to remaining at Mrs C's side. This would mean that she would not have had to be moved downstairs.

78. Although we cannot say whether the movement downstairs directly contravened the care plan, we still consider this to be fault, for the reasons given. Again, it is clear that the fact that Mrs C was not comfortable when she died has caused distress to her family.

Treatment of safeguarding concerns

79. Ms J complains that safeguarding concerns she raised with the Council were treated as a normal complaint.

80. Ms J wrote a letter to the Council on 7 March 2017. In addition to the points of complaint which we have investigated here, she provided a list of issues with Mrs C's treatment at Oakwood before her death. She wrote that the family had raised these issues with the care home at the time, and that they had wished to move her to a different home, but had decided against it because she was too frail.

81. The Council responded to Ms J's concerns under its normal complaint procedure. At Stage 2, it acknowledged that this should not have happened, and that a safeguarding concern should have been raised instead. But it says that its

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investigation of the issues (as a complaint) followed the same lines as a proper safeguarding investigation, and that there was therefore no substantive difference in the outcome.

82. The Stage 2 response also says that the Council had now raised the safeguarding concerns to the CQC.

83. We cannot investigate Oakwood's handling of any safeguarding concerns which were raised before Mrs C's death. This is because it has been more than 12 months since these events.

84. Much of Ms J's letter dealt with the family's complaints, as we have investigated here, and it may be that this led to the whole letter being treated as a complaint. But Ms J specifically wrote that she and the rest of the family had serious safeguarding concerns about Oakwood.

85. Under section 42 of the Care Act 2014, a council must make necessary enquiries if it has reason to think a person may be at risk of abuse or neglect, and has needs for care and support which mean he or she cannot protect himself or herself. It must also decide whether it or another person or agency should take any action to protect the person from abuse or risk.

86. It was fault that this part of the letter was not handled separately under safeguarding protocols. While it was sadly too late for concerns specifically about Mrs C to be investigated, the issues raised in Ms J's letter may have equally applied to other residents at Oakwood.

87. The Council has accepted this error in its Stage 2 response to Ms J. But it says that its investigation of the complaint followed the same lines of enquiry as a safeguarding investigation – for example, by undertaking Safe and Wellbeing checks on the residents at the home. The Council subsequently referred the matter of poor record-keeping to the CQC.

88. Once our investigation began, the additional information about poor record-keeping has led to a further referral to the CQC.

89. We accept the Council's point here. Safeguarding investigations have a statutory structure, and we would generally expect a safeguarding inquiry to be more robust than a normal complaint investigation.

90. But, in this case, the complaint investigation ultimately established areas of serious concern about Oakwood, in particular its poor record-keeping, which resulted in the home's referral to the relevant authority.

91. It appears likely that a proper safeguarding investigation would have led the Council to the same course of action. So, in this instance, it does not appear that anything was lost by the failure to handle Ms J's safeguarding concerns appropriately.

92. But it is still important for the Council to show that it has taken remedial steps, to ensure that a similar error will not recur.

Loss of records

93. During the Council's complaint investigation, Oakwood was unable to locate several important records about Mrs C. This included its night diary from the time of her death, her end-of-life care plan, and the 'do not attempt CPR' instruction.

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94. During the initial stages of our investigation, the night diary was located by Oakwood. But Mrs C's care plan and 'do not attempt CPR' instruction are still missing.

95. This is significant fault. Adequate record-keeping is a legal requirement for care homes. This is especially so when considering that the missing records relate to a death. If, for example, there had subsequently been a dispute that a valid 'do not attempt CPR' instruction was in place, its loss could have extremely serious consequences.

96. Even with the records which are available, there are clear inadequacies. For example, the entry in the night diary quoted previously is confusing and contradictory. Given that it represents a key record about a death, it is not acceptable for it to fail to give the reader a clear indication of what had occurred.

97. We also note, as mentioned previously, that Oakwood apparently has no record of the GP's visit on 19 April.

98. There is a consistent theme of inadequate record-keeping through the different elements of this complaint. This suggests a systemic problem at Oakwood.

99. The Council says that, since Mrs C's death, it has undertaken visits to Oakwood. It says that the care home, which is now under new management, has demonstrated improvements in its record-keeping. But, given the additional concerns which have come to light since our investigation began, it has referred the concerns about Oakwood's record-keeping to the CQC.

100. Although we have serious concerns about this matter, we consider the CQC referral to be the appropriate response. And so we do not consider there is further action for the Council to take at the current time.

The Council's complaint handling

101. Ms J complains that the Council's investigation of her complaint has been inadequate. She was particularly dissatisfied with the Council's Stage 1 response, which she found to be insensitive.

102. Mrs H originally complained directly to Oakwood in May 2016, and notified the Council that she did so. There appears to have been some missed communications between Oakwood and Mrs H after this, although the reasons for this are unclear.

103. Ms J took responsibility for handling the family's complaints in March 2017. This was the letter in which she also raised her safeguarding concerns.

104. The Council made its Stage 1 response on 21 July. It explained that there had been difficulty investigating Ms J's complaints, due to the various missing records and the fact that the relevant staff were no longer in post. This included the question of whether CPR had been attempted, which was not recorded in any of the (then) available records.

105. But the Council agreed that it was unacceptable that Oakwood had not contacted the family to inform them of Mrs C's deterioration.

106. The Council also explained that, in response to Ms J's safeguarding concerns, it had conducted Safe and Wellbeing checks with each of the residents at Oakwood. This had not triggered any further concerns.

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107. Ms J requested a Stage 2 complaint response on a date which is not recorded, but which the Council said it received on 29 August. She and Mrs H raised several points about the initial response which they considered inadequate. These included that a breach of data protection had occurred (we assume this relates to the lost records), the failure to conduct a safeguarding investigation, and the failure to ask the GP to examine Mrs C during his visit on 19 April.

108. The Council made its Stage 2 on 20 October. It explained that the loss of records had now been referred to the CQC, and although it could not confirm that the GP had visited, it agreed that this would have been an opportunity to have Mrs C examined if it had happened.

109. The Council also apologised for the failure to notify the family of Mrs C's deterioration, and that they had been notified by the police of her death. It also acknowledged that it was wrong for Ms J's letter not to have raised a safeguarding investigation, but explained that its complaint investigation had ultimately led to a similar outcome to any likely safeguarding investigation.

110. We appreciate why Ms J and her mother were dissatisfied with the Stage 1 response. It failed to address some key points they had raised, and left some important questions unanswered.

111. We do understand the difficulty the Council encountered in investigating the complaint, given the various important documents which were missing. There was, for example, no way of objectively confirming the CPR attempt at that stage.

112. But, as Ms J says, the Council appears to have regarded the loss of records simply as unfortunate, rather than something on which formal action was needed. The Council should, for example, have referred this matter to the CQC as soon as it was aware of it. It would also have been best practice to refer it to the Information Commissioner's Office (ICO), which the family had to do instead.

113. We consider there to be fault in the poor response the family received at Stage 1. The Council did not recognise how serious its own findings were, nor did it appear to recognise the distress the family had experienced because of Oakwood's failings.

114. We do consider the Council's Stage 2 response to be of a notably better standard. Although its findings were still hampered by the loss of records at this stage, it accepted that there were serious problems in what had occurred at Oakwood. It said that it was referring matters to the CQC, and made efforts to acknowledge how the family felt about what had happened.

115. However, the Stage 1 response was such that it appears to have added to the family's already considerable distress.

Conclusions

116. There were several areas of significant fault surrounding Mrs C's death.

117. Oakwood made no serious effort to inform Mrs C's family of her deterioration, nor of her death. This meant that the family did not have an opportunity to say goodbye to her, and that the first they knew of the situation was when the police notified them that she had died. This caused them a considerable amount of avoidable distress.

118. Oakwood did not seek medical advice about Mrs C's deterioration until a few hours before she died. The home also missed an obvious opportunity to have her

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examined by the GP during his visit. It is not clear that this ultimately made any material difference to Mrs C's situation, but is an example of poor practice.

119. Care staff moved Mrs C downstairs shortly before her death, with no apparent justification. On the balance of probabilities, this meant that she was not in comfort when she died.

120. The Council failed to treat safeguarding concerns properly, dealing with them instead through its normal complaints process. It appears that this led to the same outcome anyway, but is a further example of poor practice.

121. Oakwood has lost several important records. This is a serious fault in its own right, and also meant that several areas of Ms J's complaint could not properly be investigated. This means the family have been denied a full response to their complaints.

122. The Council's Stage 1 response was inadequate, failing to recognise both the severity of its findings, and also the distress caused to the family. This caused them additional avoidable distress.

Recommendations

123. To remedy the injustice identified in this report, we recommend the Council should:

- pay Ms J £1000 to recognise the distress she and her family has suffered because of the loss of opportunity to say goodbye to Mrs C, and a further £300 because of the additional distress caused by the poor response to their Stage 1 complaint, and £200 for the failure to maintain full records of these events, which have prevented the family from receiving a full response to their complaints;
- ensure that it has published clear guidance for care home staff on when to notify next of kin, in the event of a resident's deterioration in health;
- ensure that it has published clear guidance for care home staff on when to seek medical advice, in the event of a resident's deterioration in health, and especially where there is a possibility of contagion;
- share this report with staff at Oakwood Care Centre; and
- ensure that all relevant staff, both at the Council and at Oakwood Care Centre, have a clear understanding of how to handle safeguarding concerns.

124. The Council must consider the report and confirm within three months the action it has taken or proposes to take. The Council should consider the report at its full Council, Cabinet or other appropriately delegated committee of elected members and we will require evidence of this. ***(Local Government Act 1974, section 31(2), as amended)***

Decision

125. Subject to further comments by Ms J and the Council, we intend to complete our investigation.

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