Appendix B

UPHELD DECISIONS

Statement Upheld Drainage 04-Mar-2019

Summary: Miss X complained the Council failed to adequately respond to her concerns about ongoing flood protection after a culvert collapsed and flooded her garden in 2017. The Council was at fault. It failed to respond to all of Miss X's concerns which caused her frustration and uncertainty. It was also at fault for the delay and handling of Miss X's complaint which caused her further frustration and uncertainty. The Council agreed to pay Miss X £150 in recognition of these faults.

- **Tameside Metropolitan Borough Council (18 009 621)**

Statement Upheld Charging 06-Feb-2019

Summary: Mr B complains the Council has failed to deal properly with the financial assessment for his father's contribution towards his care home fees. The Council is currently reviewing its handling of Mr B's complaint and in doing this will consider new information he has provided. We will discontinue our investigation so the Council can complete its review and consider the new information.

- **Tameside Metropolitan Borough Council (18 010 149)**

Statement Upheld Child protection 31-Jan-2019

Summary: Miss B complains about the way the Council dealt with a safeguarding matter concerning her children. The Ombudsman has investigated whether the Council properly considered the findings and recommendations of the independent statutory investigation into her complaint. We have found it has carried out the recommendations that were made and the payment it offered Miss B was appropriate and in line with the Ombudsman's Guidance. However, it was at fault for the length of time it took to deal with Miss B's complaint. We have also found it was at fault for taking too long to deal with the concerns raised by the investigating officer about a social worker. We recommend the Council considers these delays and decides whether to put measures in place to prevent them from reoccurring. We also recommend it writes to Miss B and invites her to submit any medical evidence which supports her case that its faults caused her and her children harm. If Miss B does this, it should consider whether to make a further payment to her. The Council has agreed to carry out these recommendations.

- **Tameside Metropolitan Borough Council (18 006 350)**

Statement Upheld Planning applications 09-Jan-2019

Summary: Ms B complains the Council has not taken enforcement action against her neighbour's loft extension. Ms B says her neighbour's extension has stopped her from using her gardens, reduced the value of her property and had a harmful impact on her mental health. The Ombudsman has not found fault with how the Council decided the extension was permitted development. The Council delayed in responding to Ms B's complaint and has apologised, this is a suitable remedy for the injustice caused.

- **Tameside Metropolitan Borough Council (18 000 260)**

Statement Upheld Charging 22-Nov-2018

Summary: Mrs X complains on behalf of her late grandmother, Mrs Y about the level of care she was provided whilst resident at Sunnyside Care Home between 2015 and 2016. She also complains about the way the Council dealt with Mrs Y's outstanding care fees and her complaint about these matters. The Ombudsman has found the Council was at fault when the Care Home failed to give notice ending Mrs Y's placement after she was admitted to hospital, and this resulted in excess charges being incurred and the Council pursuing the debt in November 2017. It was also at fault for the way it handled Mrs X's dispute about the outstanding bill, and the way it dealt with her complaint. She incurred unnecessary time and trouble in making the complaint and the Council's actions caused both her and her family distress. To remedy this injustice, the Council has agreed to apologise and make a small payment to Mrs X.

- **Tameside Metropolitan Borough Council (18 005 352)**

Statement Upheld School admissions 10-Nov-2018

Summary: Mrs B complains about delay by the Council in an appeal for a secondary school place for her child. The Ombudsman finds there was fault, and that as a result Mrs B was caused injustice. The Council has agreed to the Ombudsman's recommendation that it apologise to Mrs B and makes her a payment in acknowledgment of the injustice caused.

- **Tameside Metropolitan Borough Council (16 015 034)**

Statement Upheld Direct payments 20-Aug-2018

Summary: There was fault in the way the Council dealt with Mr Y's disability related expenses, financial assessments and direct payment audits as described in detail in this statement. To remedy the injustice, the Council will backdate allowances/disregards, write off debts, make a payment to Mr Z, Mr Y's father, for his avoidable time and trouble and take other action described in the statement.

- **Tameside Metropolitan Borough Council (17 006 787)**

Statement Upheld Child protection 30-Jul-2018

Summary: Miss X complains the Council has failed to ensure she has contact with her two daughters and she has not seen them in two years. The Ombudsman finds the Council at fault and recommends it pays Miss X £750 for uncertainty and invites her to an assessment regarding contact.

- **Tameside Metropolitan Borough Council (17 011 594)**

Statement Upheld Licensing 18-May-2018

Summary: Mrs X complained about how the Council investigated her concerns about a taxi company that it licenses. The Council was not at fault in how it investigated the incident and it was entitled to decide to issue a warning to the driver. However, the Council was at fault for not keeping proper records of its investigation. This fault did not cause Mrs X an injustice.

- **Tameside Metropolitan Borough Council (17 020 072)**

Statement Upheld Assessment and care plan 30-Apr-2018

Summary: The Ombudsman will not investigate Mr and Mrs A's complaint about the Council's actions when determining their son's, Mr B's, contribution towards his care package. This is because the Council has apologised for its failings and cancelled an initial invoice because of its delay in completing Mr B's financial assessment. T here is no unremedied injustice for the Ombudsman to investigate.

Appendix C

SATISFACTORY REMEDY DECISIONS

Statement Upheld Planning applications 09-Jan-2019

Summary: Ms B complains the Council has not taken enforcement action against her neighbour's loft extension. Ms B says her neighbour's extension has stopped her from using her gardens, reduced the value of her property and had a harmful impact on her mental health. The Ombudsman has not found fault with how the Council decided the extension was permitted development. The Council delayed in responding to Ms B's complaint and has apologised, this is a suitable remedy for the injustice caused.

- **Tameside Metropolitan Borough Council (17 020 072)**

Statement Upheld Assessment and care plan 30-Apr-2018

Summary: The Ombudsman will not investigate Mr and Mrs A's complaint about the Council's actions when determining their son's, Mr B's, contribution towards his care package. This is because the Council has apologised for its failings and cancelled an initial invoice because of its delay in completing Mr B's financial assessment. T here is no unremedied injustice for the Ombudsman to investigate.

Appendix D

Recommended Service Improvements

- Case Ref: **16 015 034** Category: Adult care services Sub Category: Direct payments

The Council has identified others affected by the previous charging policy and repays any charges it has levied to others which were not in line with the law and guidance in force before 1 April 2015. Within three months of my final decision, the Council will ensure all those affected are repaid and inform me of the amounts refunded in each case.

- Case Ref: **17 012 757** Category: Adult care services Sub Category: Safeguarding

The Council has also agreed to undertake a number of service improvements. It is introducing a revised Safeguarding Adults Policy, and will provide updated training to relevant staff. It will also refresh staff understanding of how to handle safeguarding concerns. It will signpost care staff to the Care Quality Commission (CQC)guidance on seeking medical advice. As part of future contracts, it will require care homes to agree with residents' families the level of notification they would like about changes in their condition, and record this in the resident's care plan. It has undertaken training for adult social care staff on handling complaints. It will share this report with staff at Oakwood Care Centre.

Oakwood Care Centre has also undertaken anumber of service improvements. It has introduced a new 'Unexpected Death Policy and Procedure', and staff will be required to sign to confirm they have read it. It will discuss the contents of this report at its next team meeting. It has introduced new care plans, which clearly indicate whether resuscitation should be attempted. The manager and deputy manager are now 'safeguarding adult' managers. It will shortly review its notification process.

- Case Ref: **18 000 260** Category: Adult care services Sub Category: Charging

The Council will issue a written briefing to all its Adult Social Care staff stating disputes about care home fees should be directed to the Billing Team. This Team should place any debt relating to a dispute on hold whilst it investigates the concerns that were raised. If after an investigation the dispute cannot be resolved, the person raising it should be informed of their right to make a complaint about the matter.

The Council will discuss the outcome of this complaint and the Ombudsman's final decision in an Adult Social Care team manager's meeting for learning purposes. The points raised should focus on the need to keep complainants updated of any delays, when and how discretion should be exercised if a complaint is late, and the need to carry out a full investigation if discretion is exercised.

- Case Ref: **18 005 352** Category: Education Sub Category: School admissions

Within three months of the date of decision, the Council is to consider lessons learned from this complaint and whether there is more it could do to mitigate the possibility of the fault identified in this case (ie a lack of school appeal panel members leading to a delay in hearing appeals) arising in future.

- Case Ref: **18 010 149** Category: Children's care services Sub Category: Child protection

The Council has also agreed that its Children's Services Senior Leadership Team will discuss the findings of the Ombudsman's investigation at its next meeting, ensuring a senior manager from the Complaints Team is in attendance. Those present will establish why the handling of the complaint and

the HCPC referral was delayed, and consider whether any measures should be put in place to prevent these faults from reoccurring. Within two weeks of the meeting, the Council will provide the Ombudsman with a record or minutes of the discussion and confirm whether it will take any action, providing reasons if it decides not to.

Public Report

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)

23 May 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

Report summary

Adult care services

Ms J complains about the actions of a care home, Oakwood Care Centre, 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

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)***

To remedy the injustice caused, we recommend that the Council should pay Ms J £1500. The Council has accepted this recommendation.

The Council has also agreed to undertake a number of service improvements.

- It is introducing a revised Safeguarding Adults Policy, and will provide updated training to relevant staff. It will also refresh staff understanding of how to handle safeguarding concerns.
- It will signpost care staff to the Care Quality Commission (CQC) guidance on seeking medical advice.
- As part of future contracts, it will require care homes to agree with residents' families the level of notification they would like about changes in their condition, and record this in the resident's care plan.
- It has undertaken training for adult social care staff on handling complaints.
- It will share this report with staff at Oakwood Care Centre.

Separately, Oakwood has also undertaken a number of service improvements, which we will discuss at the end of this report.

The complaint

1. The complainant, Ms J, represents her late grandmother, Mrs C. Mrs C passed away in Oakwood Care Centre in April 2016, and Ms J complains about the way her death was handled by the care home.

2. Specifically, Ms J says that:

- Oakwood did not inform the family Mrs C's condition was deteriorating, and did not make serious efforts to inform them she had died. This meant 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 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
- 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.

8. We also shared a draft copy of the report with Ms J, the Council and Oakwood Care Centre for their comments.

Findings

9. 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.

10. 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 Mrs C's needs were being met at that time, and a reassessment was scheduled in a year's time.

11. On 17 April 2016, Mrs C's family visited her at Oakwood. She was well at this point.

12. 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.

13. In the evening of 19 April, a carer called the out-of-hours GP for advice. The carer advised 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.

14. The GP called back and said, 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.

15. At this point, the carers recorded that Mrs C had vomited in bed and her breathing had become rapid. They decided to move her downstairs to the lounge so they could monitor her.

16. At approximately 12.35am on 20 April, Mrs C stopped breathing. Oakwood called an ambulance. When the ambulance arrived, the paramedics confirmed she had died.

17. 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.

18. The police attended Oakwood to take statements shortly after Mrs C died. The police then broke the news of her death to Mrs H.

19. Mrs H wrote a letter of complaint to Oakwood on 24 May, and informed the Council she had done so. The manager of the care home responded initially on 10 June, and then more formally on 25 July.

20. Ms J complained to the Council in March 2017. She included a list of safeguarding concerns in her letter.

21. The Council responded at Stage 1 on 21 July. It explained there were various records missing from Oakwood, and the care staff involved had since left post. It upheld some of Ms J's complaint, and explained it undertaken Safe and Wellbeing checks on the residents at the care home.

22. Ms J requested a Stage 2 response in August. The Council responded on 20 October. It upheld further elements of the complaint, and confirmed Oakwood's record-keeping had now been referred to the Care Quality Commission (CQC).

Analysis

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

Communication with family

24. 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 Mrs C had already died. The police informed the family of Mrs C's death, which was the first they knew about her deterioration.

25. Oakwood's day diary records 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 about the date on which Ms J visited, or that different family members visited on each day.

26. However, it is clear from the day diary 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).

27. 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.

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

29. 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 Mrs C had remained in bed, had not eaten or drunk and was suffering diarrhoea and vomiting.

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

31. 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 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.

32. 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.

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

34. 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

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.

35. The Council has acknowledged 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.

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

Lack of urgency in seeking medical advice

37. 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 not well.

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

39. The day diary notes the out-of-hours GP said they would call back "within the hour (9pm)", indicating 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 this is due to confusion over the fact that the GP called Oakwood back.

40. In either case, there is no record 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'.

41. 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.

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

43. 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."

44. 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."

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

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

47. Even accepting this, though, we agree that 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.

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

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

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

- decide whether the cause of death is clear;
- request a post-mortem to find out how the person died if the cause of death is not clear; and
- hold an inquest after the post-mortem 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.

51. It is evident 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 her symptoms might have remained unexplained, even after examination by a doctor, and the post-mortem would still have been necessary.

52. We appreciate 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 it was because of fault by Oakwood.

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

54. The Council has told us, since Mrs C's passing, it has undertaken work to improve communication between care homes and GPs. It says there is now greater integration between the Council and local NHS Trust, and 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.

55. 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.

56. 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

57. 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 CPR had been performed.

58. 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."*

59. 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.

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

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

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

63. It may be 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 this is unclear.

64. 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.

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

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

67. In isolation, we would not criticise the staff for this. They had made it clear when summoning the paramedics 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.

68. It may be the paramedic made an error of judgement. If so, this would fall outside of our jurisdiction. Alternatively, it may be 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 not able to draw a conclusion on this.

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

Failure to follow care plan

70. Ms J says 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.

71. We can see from the night diary 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 Mrs C passed away in a wheelchair.

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

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

74. The staff wrote 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.

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

76. The staff recorded 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.

77. 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 the staff considered that Mrs C was likely to be approaching death.

78. Given this fact, we consider 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.

79. 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, the fact that Mrs C was not comfortable when she died has caused distress to her family.

Treatment of safeguarding concerns

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

81. 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 they had wished to move her to a different home, but had decided against it because she was too frail.

82. The Council responded to Ms J's concerns under its normal complaint procedure. At Stage 2, it acknowledged this should not have happened, and a safeguarding concern should have been raised instead. But it says its investigation of the issues (as a complaint) followed the same lines as a proper safeguarding investigation, and there was therefore no substantive difference in the outcome.

83. The Stage 2 response also says the Council had now raised the safeguarding concerns with the CQC.

84. 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.

85. Much of Ms J's letter dealt with the family's complaints, as we have investigated here, and it may be this led to the whole letter being treated as a complaint. But