Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against the South Eastern Health and Social Care Trust

NIPSO Reference: 201913337

The Northern Ireland Public Services Ombudsman
33 Wellington Place
BELFAST
BT1 6HN
Tel: 028 9023 3821
Email: nipso@nipso.org.uk
Web: www.nipso.org.uk
@NIPSO_Comms

The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

Case Reference: 201913337
Listed Authority: South Eastern Health & Social Care Trust

SUMMARY

I received a complaint from two sisters (A and B), regarding the actions of the South Eastern Health & Social Care Trust (the Trust). Sister A and sister B lived in Scotland. The complaint concerned their elderly mother (the service user) who had Alzheimer's disease. Their mother lived alone in Northern Ireland and sister A exercised formal responsibility for her finances from Scotland. A third daughter, sister C, lived locally.

Sister C believed her mother could be cared for in her own home, whereas A and B believed she could only be properly cared for, and safe, if she was placed permanently in a care home, preferably a care home in their local area in Scotland where the service user's sister lived. Although there was evidence their mother preferred to remain in Northern Ireland, the complainants doubted that she had the capacity to decide what was in her own best interests. Unfortunately Sister C's relationship with sisters A and B had broken down and they had no faith in sister C's ability to look after their mother.

The complainants said the Trust considered sister C to be the primary carer and they felt excluded. They believed the Trust ignored their concerns and failed to manage their mother's capacity which, they claimed, compromised her care and ultimately led to her death.

I gathered all relevant information, including health and social care records showing the involvement of the Trust and the interactions between the parties. I obtained independent professional psychiatric and care management advice.

After the service user was first assessed as lacking capacity, I found several occasions where the Trust did not include the complainants in the deliberations to establish her best interests, despite their connection and their desire to contribute.

Acknowledging the challenge of the acrimonious family relationship, I found evidence of a (now retired) Care Manager's poor professional judgement in respect of comments made and information shared with sister C. There was also a failure to share relevant care documentation with the complainants.

I concluded there were failures in the Trust's management of events which aggravated the siblings' relationship and tarnished the Trust's role as an impartial provider of care. I partially upheld the complaint.

I recommended that the Chief Executive apologised to the complainants; and care management staff be formally reminded of the significance of their role, with particular reference to the issues highlighted in this report, namely:

- handling difficult family relationships;
- the value of agreeing terms of engagement with family members;
- sharing information; and
- the importance of impartiality.

The Chief Executive of the Trust accepted my findings and recommendations.

THE COMPLAINT

1. I received a complaint from two sisters (A and B) about the actions of the South Eastern Health & Social Care Trust (the Trust). The complainants (who lived in Scotland) said the Trust *'ignored'* their requests for assessment of their elderly mother (the service user) by a psychogeriatrician and so failed to manage her capacity and act in her best interests. Their mother lived at home in Northern Ireland. The complainants were dissatisfied because the Trust *'routinely claimed [their mother] had capacity to make vital decisions about her future care'*, in particular where she should live and how her care needs should be met.

2. The complainants felt the Trust's Care Manager did not act impartially towards them. Instead they believed he *'acted with, and was manipulated by'* a third sister, C, to the detriment of their mother. Sister C lived locally to her mother and was involved in her care.

Background

3. The service user (sadly now deceased) was diagnosed with Alzheimer's disease in 2005.

4. In 2013 the Care Manager arranged a package of care partly funded by the Trust to support the service user at home. Sister A and sister B were wary of the arrangement because they doubted their mother had the mental capacity to make decisions, particularly the decision where, in her best interests, she should live in order that her care needs could be met.

5. Sister C believed her mother could be cared for in her own home, whereas A and B believed she would be properly cared for, and safe, if she resided permanently in a care home, specifically a care home in their local area in Scotland where her sister lived. Although there was evidence their mother preferred to remain in Northern Ireland, the complainants did not believe she had the capacity to decide what was in her own best interests.

6. On 30 January 2015, the service user was placed in Care Home One for rehabilitation having sustained a fractured left hip following a fall at home. She was discharged on 16 February 2015.

7. On 23 March 2018, the service user was placed in Care Home Two for rehabilitation having sustained a fractured right hip following a fall at home.

8. A full chronology can be found at Appendix three.

Issues of complaint

9. The issues of complaint accepted for investigation were:

Issue 1: *Whether the Trust acted appropriately in relation to family concerns about the service user's capacity and considered the service user's best interests in making decisions.*

Issue 2: *Whether the Trust acted appropriately in relation to family concerns about where the service user should be cared for and, took account of the service user's best interests in making decisions.*

INVESTIGATION METHODOLOGY

10. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues raised by the complainant.

Independent Professional Advice Sought

11. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisors (IPA):
    - Care Manager IPA, RMN MSc FCMI MAPM; a Registered Mental Nurse with over 35 years of experience;
    - Psychiatrist IPA, MBChB, FRCPsych; a Consultant Psychiatrist with experience in General Adult Psychiatry.

    The clinical advice received is enclosed at Appendix four to this report.

12. The information and advice which informed the findings and conclusions are included within the body of this report. The IPAs provided 'advice'; the reader should note that how this advice was weighed, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

13. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case. I also make reference to relevant regulatory, professional and statutory guidance. The general standards are the Ombudsman's Principles[1]:

    - The Principles of Good Administration
    - The Principles of Good Complaints Handling

14. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

15. The specific standards and guidance relevant to this complaint are:

    - NICE[2] - Dementia: supporting people with dementia and their carers in health and social care, 2006 (CG42);
    - Consent *patients and doctors making decisions together* (GMC 2008)
    - NICE - Dementia: support in health and social care, 2010 (QS1);
    - NICE - Dementia: independence and wellbeing; 2013 (QS30);
    - The Seven Principles of Public Life, 1995 (The Nolan Principles);
    - Mental Capacity Act (Northern Ireland) 2016 (MCA);
    - Five Principles established by the Mental Capacity Act 2005[3];

[1] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

[2] National Institute for Health and Care Excellence

[3] Although the Mental Capacity Act 2005 does not apply in Northern Ireland, the Care Manager IPA advised that the five principles contained therein are nonetheless relevant to this case.

- Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services, 2011 (NICE CG136); and
- Nursing and Midwifery Council Code, 2015 (NMC Code).

Relevant sections of the guidance considered are referred to within the professional advice obtained during the investigation, Appendix four.

16. I did not include all of the information obtained in the course of the investigation in this report. I am satisfied that everything that I consider to be relevant and important was taken into account in reaching my findings.

17. A draft copy of this report was shared with the complainants and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Issue 1: *Whether the Trust acted appropriately in relation to family concerns about the service user's capacity and considered the service user's best interests in making decisions.*

Issue 2: *Whether the Trust acted appropriately in relation to family concerns about where the service user should be cared for and, took account of the service user's best interests in making decisions.*

Detail of Complaint

18. The complainants said *'the outstanding issue of this complaint is that the South Eastern Health and Social Care Trust routinely claimed [their mother] . . . who suffered from Alzheimer's, had capacity to make vital decisions about her further care.'*

19. The complainants said their *'repeated requests for assessment [of their mother] by an expert geriatric psychotherapist were ignored in favour of inexpert assessment from the insufficiently qualified.'*

20. The complainants said *'[their mother's] mental state was deteriorating and she was vulnerable in her own home.'* The complainants said their mother *'suffered four bad falls and a dog bite while at home'*; her injuries included two separate hip fractures in 2015 and 2018. '*Further family concerns were rejected by the Trust on the grounds that [their mother] 'had capacity''*.

21. The complainants said the Care Manager *'acted with, and was manipulated by, [their sister C].'* They said: *'To consider [C] as [their mother's] primary care giver while viewing her speculations regarding [their mother] as trustworthy, against considerable evidence to the contrary, was maladministration of the worst order.'*

22. The complainants said: *'The dependence on faulty procedures by the Trust, and in particular [the Care Manager] and his senior managers, resulted in advice that was wholly misleading or inadequate. The Trust showed clear unfairness, bias and prejudice which ensured avoidable delays, leading directly to [their mother's] death.'*

23. Referring to their mother's stay in hospital in the early part of 2018 following a hip fracture, the complainant's said their mother *'had been approached in hospital, and asked if she wanted to live in Scotland, a clumsy and extraordinarily insensitive move on the part of the Trust. [Their mother] was in no way capable of understanding the consequences of her response, and predictably stated that she wanted to go home . . .'*

24. At this stage of the investigation, I consider it would be helpful to address issues one and two together under the following headings:
    a) The Trust's management of the service user's capacity
    b) Conduct of the Care Manager
    c) Timing of placement in 2018

a) The Trust's management of the service user's capacity

Evidence Considered

Legislation/Policies/Guidance

25. I considered the following legislation and guidance:
    - *Consent: patients and doctors making decisions together* (GMC 2008)
    - Mental Capacity Act (Northern Ireland) 2016;
    - Five principles of the Mental Capacity Act 2005[4];
    - CG42; and
    - CG136.

Trust's response to investigation enquiries

26. While not having undertaken *'any formal training in capacity assessment'*, the Trust said the Care Manager was a *'Registered Mental Nurse with 30 years' experience.'*

27. The Trust said *'[the service user's] capacity to make decisions about her care was determined on several occasions since 2013. . . . This is evidenced within the Care Management files . . .'* (The chronology at Appendix three contains the specific dates.)

28. In relation to a referral in March 2015 made by a Specialist Occupational Therapist (OT) which stated the service user would benefit from a psychogeriatrician review, the Trust said:
'There is nothing in the [care management] notes relating to a referral in March 2015.'

29. The Trust said, *'as documented in the Community Care files, the Trust sought to balance wishes and views of all parties, while working to ensure [the service user's] needs were central to all processes.'*

30. Referring to the immediate period after the psychiatric report of 2 June 2016,

[4] Although the Mental Capacity Act 2005 does not apply in Northern Ireland, the Care Manager IPA advised that the five principles contained therein are nonetheless relevant to this case.

the Trust said:

'There is no documentary evidence of the information given to the family regarding the outcome of the assessment completed on 27 April 2016 and received by the Trust on 2 June 2016.'

'*Whilst no formal family meetings or best interest meetings were held at this time, [the Care Manager] remained closely involved and available for all family members. The family were offered the opportunity to meet collectively to discuss the welfare concerns of their mother and an offer of the Trusts Family Group Conferencing Service was made . . .'*

31. Referring to the review conducted on 6 April 2017 by the Care Manager, the Trust could not confirm whether the complainants were given an opportunity to contribute to the consideration then given to where their mother should reside. The Trust said:

'*There is no documentary evidence of this contact between the complainants and the Trust; however the Trust can confirm that [sister C] was involved in this process. In hindsight the Trust recognises that particularly where family dynamics are contentious; it is good practice to obtain all viewpoints.'*

32. The Trust acknowledged that a statement in a letter to sister B of 17 April 2018 *'regarding [the service user] having capacity was misleading and objectively incorrect and apologises for any stress or confusion this may have caused.'*

Relevant Trust records

33. The following Trust records were considered:

- A written report of a psychiatric assessment of the service user's capacity conducted on 16 December 2013 and a written record of the assessor's telephone conversation with sister A on 30 December 2013;
- A written report of a psychiatric assessment of service user's capacity conducted on 27 April 2016;
- A completed pro forma of a review of the service user's care needs conducted by the Care Manager on 24 February 2015;
- A written report of a psychiatrist's assessment of the service user's capacity conducted on 27 April 2016;

- A completed pro forma of a review of the service user's care needs conducted by the Care Manager on 6 April 2017; and
- A completed pro forma of a review of the service user's care needs conducted by the Care Manager on 15 August 2017.

Relevant extracts are contained in Appendix five.

Relevant Independent Professional Advice

34. The Psychiatrist IPA advised:
'Formal assessment in a patient with dementia such as Alzheimer's Disease would usually involve a medical professional such as the patient's General Practitioner (GP) or a Consultant Psychiatrist. This may however also be undertaken by a suitably qualified Nurse or Social Worker as the emphasis is on expertise and knowledge of the patient and the illness that they are diagnosed with rather than specific professional grouping.'

35. Referring to the psychiatric assessment conducted in December 2013, the Psychiatrist IPA advised:
***'**Given the patient's presentation of mild to moderate dementia with assessed capacity to make informed decisions regarding her place of residence and ongoing management I cannot identify any rationale for scheduling a future assessment of capacity. If the patient had an advanced dementia or if there was any doubt as to capacity this might be reasonable however given the patient's recorded symptoms and presentation a decision to schedule a further assessment would be highly unusual and attract significant scrutiny as regards meeting the patient's best interests.'*

36. The Psychiatrist IPA advised:
'Whilst the only Psychiatric assessment of the patient prior to her discharge from [Care Home One] in February 2015 was in December 2013, there is a clear view of the patient's capacity recorded by her Care Manager . . . in his assessment of 24.02.15. It is clear from the record that the assessor has taken into account the patient's previously expressed and current wishes which would have been a key factor in determining best interests even if the patient had lost capacity.'

37. The Psychiatrist IPA advised:
'Whilst it is not unknown for a patient to regain capacity after having been assessed to have lost capacity, for instance once a severe mental illness responds to treatment, in a progressive neurodegenerative disease such as Alzheimer's Disease it would be unusual for a patient to regain capacity.'

38. The Psychiatrist IPA advised:
'It is clear there were differing views expressed by the patient's family members as to what might be in the patient's best interests. In such circumstances the records indicate that the Trust was guided by the patient's currently expressed views whilst she retained capacity and thereafter were mindful of her clear, consistently expressed views when she lost capacity. This is consistent with good practice.'

39. The Care Manager IPA advised:
'*The common theme with all the standards and guidance is that the individual's needs (ie the service user) are paramount and are at the centre of any care planning decisions. All decisions should be in the individual's best interests and, wherever possible, in line with their wishes. That may include care planning decisions that family members do not agree with, and that perhaps do not even seem to be sensible, or perhaps even safe, decisions. It is important to recognise that even where an individual does lack capacity, or has very limited capacity, that they may still be capable of expressing their wishes and preferences. Where possible and within the realms of relative safety then their wishes should be honoured.'*

Other information considered

The complainant's response to the draft report

40. The complainants believed *'an assumption has been made throughout [the draft] report, due to a lack of documentation, that by living locally, Sister C could be assumed to be the service user's main carer.'* The complainants said: *'It is vitally important to understand that this assumption is wholly inaccurate.' The complainants said: 'Sister C cannot be defined as the main carer simply*

because of her location.'

The complainants said: *'This erroneous assumption directly impacts the subsequent interpretation from the experts and the reading of certain elements.'*

41. The complainants wished to make it clear that sister A was the main carer: *'Sister A was entirely responsible for every aspect of the service user's welfare through a private care package instigated by her father (the service provider's husband) and implemented and managed by Sister A, with additional limited care provided by the Trust.'*

'Sister A was the main carer and sister C was one member of a team who lived locally and who contributed to the care package.'

42. The complainants said: '*This dispute was about a particular issue, we repeat - whether there was sufficient assessment undertaken at a senior level to assess the service user's capacity to make realistic and informed decisions. The fact remains that once this assessment was undertaken at the proper level and her lack of capacity was confirmed, had this information been forthcoming and Sisters A & B included in resultant discussions, that dispute could have been resolved.'*

43. The complainants noted that the Care Manager, and the psychiatrist who conducted the second psychiatric assessment, together decided the service user was *'likely to be extremely distressed if forced to move from her own home'*.

The complainants said:

'Having been erroneously excluded from discussion, Sisters A and B were prevented from suggesting that should the service user have been distressed by a move that this would have been mitigated very quickly, as was the case on several occasions when she spent time away from her home.'

The Trust's response to the draft report

44. The Trust said it was aware of the Care Manager's views on the draft report which it confirmed had been shared with the Care Manager.

45. In relation to the OT referral in March 2015, the Trust acknowledged and regretted the lack of recorded evidence to show the consideration given to the referral. Noting that one month earlier, in February 2015, the service user had been recorded as being able to make informed choices, the Care Manager considered *'that this, and the consistency in [the service user's] expressed wishes, is likely to be the reason why the OT recommendation was not acted upon.'*

46. The Trust said:
'Recognising that review is not a static event, sisters A and B were welcome to engage in and contribute their views to the review process on an ongoing basis. On occasions, A and B availed of this opportunity, while at other times they did not respond to formal invitations.'

Analysis and Findings

47. I note the GMC guidance 2008[5] stated:
'In Northern Ireland there is currently no relevant primary legislation; and decision-making for patients without capacity is governed by the common law, which requires that decisions must be made in a patient's best interests.'[6]

48. I note the Mental Capacity Act (NI) 2016 introduced primary legislation which included a principle of best interests that requires:
'any act done or decision made under the Act on behalf of a person who is 16 or over and lacks capacity, to be in that person's best interests.'[7]

49. I note the Care Manager IPA advised that the key principles of the Mental Capacity Act 2005 are relevant to this case, although it is acknowledged that the Act itself does not apply in Northern Ireland. I note Principle 4 reads:
'Anything which is done on behalf of someone who lacks capacity must be done in their best interests.'
I accept the Care Manager IPA advice given the relevance of best-interests considerations in Northern Ireland outlined above.

---

[5] *Consent: patients and doctors making decisions together*
[6] Paragraph 62
[7] Taken from the Explanatory Notes – Principle: best interests

I note the Care manager IPA made reference to the Act's Code of Practice in the same way and I had regard for chapter 5 of that Code which provides more details on the concept of *best interests*.

50. The first Principle of Good Administration, '*Getting it right'*, includes the following:
'Public bodies must act in accordance with recognised quality standards, established good practice or both . . . '
I used this principle to assess the actions of the Trust highlighted below which I consider to be relevant.

First psychiatric assessment

51. I note that by 2013 the complainants had reached a view that an assessment of their mother by a psychogeriatrician was required to determine her level of capacity. In March 2013, I note sisters A and B raised specific concerns with the Trust about whether their mother had the capacity to decide the best place where she should live in order to be safe and to enjoy a good quality of life.
I note the Trust responded by organising a psychiatric assessment which was subsequently conducted in December 2013. I note the assessor, a Specialist Registrar to a Consultant Psychiatrist employed by the Trust, found that the service user did have capacity at that time. I note the assessor spoke to sister A in relation to these findings and recorded that sister A agreed.

52. Although A and B continued to have genuine concerns as to whether their mother could be safely cared for at home, I am satisfied that she had the capacity to decide for herself at that time. I consider the service user was free to choose that option even if it meant accepting a level of risk which the complainants considered to be too high.

53. I note that, in January 2015, one year after the Specialist Registrar's report, the service user had a fall at home and fractured her left hip. I note the service user was placed in Care Home One for a period of rehabilitation but was discharged relatively soon after, in February 2015. A record of the discharge included the wording:

'Daughter [C] keen to take her mother home.
Advised 24 hr supervision required.'
The Trust informed the investigating officer that the service user did not *'leave [Care Home One] against the advice of the Trust.'* I note *'the Trust advised the continuation of 24 hour supervision to promote a safe environment and promote the transition back home';* something which *'[sister C] agreed to undertake.'*

54. I note the complainants were concerned their mother was permitted to leave Care Home One to live at home only five weeks after her hip replacement. They did not consider this move to be in her best interests. In contrast, in February 2015, I note the Care Manager acknowledged the service user's expressed desire to live at home, and recorded that *'she was still able to make some informed choices'.* I accept the Psychiatrist IPA's advice that other views, for example, those expressed by the Care Manager were relevant given his experience and knowledge of the service user. While I recognise the complainants were concerned that the Care Manager was *'manipulated'* by their sister, C, I believe it would be unreasonable for me not to take account of the Care Manager's relevant 30-years previous experience as a Mental Health Nurse.

55. I do not consider the question of best interests was relevant because the service user was deemed capable of deciding where she should live. Since sister C was the daughter who lived locally to the service user, and in more frequent face to face contact, I acknowledge there was greater potential for her to be an influence on her mother's view of what might be in her best interests. I appreciate this was a source of frustration for sister A and sister B given the acrimonious relationship that existed with C and their view that she was unreliable and lacked wisdom. However, I have not found the Trust's actions to be in conflict with the first Principle of Good Administration. I therefore do not uphold the complaint in relation to this aspect of the Trust's handling of the served user's capacity.

<u>Second psychiatric assessment</u>

56. I note that a Specialist Occupational Therapist (OT) from the Trust's

Community Rehabilitation Team conducted an assessment in March 2015 in relation to the provision of *'assistive devices and minor adaptations'* to the access of the service user's home. The OT recorded the following recommendation:

'[The service user] is alert and uses memory aids to cue her orientation to time. Although she demonstrated some difficulties with short term memory she is able to converse superficially about recent events. Her long term memory appears intact. She is able to follow instruction, no difficulties with concentration or attention levels but would need assistance with higher cognitive integration tasks eg. Problem solving, medication, complex domestic tasks. [The service user] would benefit from Psychogeriatrician review.'

57. I note the OT made an onward referral to *'Care management regarding [personal alarms for the elderly] and Psychogeriatrician Assessment'* which was *'returned to'* the Care Manager on 18 March 2015. However, I have found no evidence to explain whether this referral was in fact acted upon. The Trust said:

'There is nothing in the [care management] notes relating to a referral in March 2015.'

The first Principle of Good Administration states that *'Public bodies should provide effective services . . .* ' In the absence of evidence to the contrary, I do not consider this requirement was met in relation to the OT's referral. I am satisfied this constitutes a failure which caused the complainants the injustice of uncertainty. Had an assessment by a psychogeriatrician been conducted as a result of the OT referral, it cannot be known whether this would have altered the official view of the service user's capacity at that time.

58. I note that a second psychiatric assessment of the service user's capacity was conducted one year later, on 27 April 2016. A report of the assessment was produced on 2 June 2016. I note the assessment occurred soon after sisters A and B wrote to the Trust in March 2016 to complain about the Trust's *'failure to recognise [their mother's] lack of capacity to make far reaching decisions . . .'* I consider it is likely this psychiatric assessment was prompted by the complaint. I note the Consultant Psychiatrist who conducted the assessment

found the service user did not have the capacity to decide where, for her own well-being, she should reside.

59. Having regard to the guidance set out by the Care Manager IPA, I consider it was from this point that, decisions which affected where the service user should live, had to be made in her best interests by those involved in her care. In my view those involved included the complainants because they were close family members who had repeatedly demonstrated an interest in their mother's care. Moreover, since sister A had power of attorney and was the formally appointed Financial Controller of her mother's estate by the Office of Care and Protection, I am satisfied there was a need for her to be given the opportunity to contribute when her mother's best interests were being considered. I consider the complainants' response to the draft report affirms the central nature of sister A's role.

60. I understand from the report that only the Consultant Psychiatrist and the Care Manager were involved in deciding the service user's best interests in June 2016. The following extract from the report refers:
'I agree with [the Care Manager] taking into account the principle of least restrictive option and human rights consideration that it is in [the service user's] best interests to remain in her own home. The level of risks appears to be an acceptable level for most people. This coupled with the fact that [the service user] herself is likely to be extremely distressed if forced to move from her own home indicates that it is in her best interests to stay in her own home at present.'
I consider this decision was in line with the Care Manager IPA advice that:
'where possible and within the realms of relative safety then [the service user's] wishes should be honoured.'

61. I note the Trust could not confirm whether the service user's family had been informed of the report findings:
'There is no documentary evidence of the information given to the family regarding the outcome of the assessment completed on 27 April 2016 and received by the Trust on 2 June 2016.'

62. Referring to the Consultant Psychiatrist's findings, I note the Care Manager IPA advised:
' . . . this would have been an appropriate point at which to hold a formal family meeting to discuss the service user's care. As such this was a missed opportunity to engage fully with all three daughters.'

63. I did not find evidence that A and B were informed of the psychogeriatrician's assessment reported in June 2016. Neither is it clear they had a specific opportunity to contribute on the first occasion their mother's best interests were being considered by the Trust. NICE guidance CG42 and CG136 refer to the importance of involving families, as articulated within the Care Manager IPA advice. I consider the Trust failed to adequately involve A and B by failing to give them an opportunity to contribute when their mother's best interests were being considered in June 2016. I am satisfied from the complainants' response to the draft report that they did have a contribution to make.

Assessment April 2017

64. I note the service user's care needs were reviewed by the Trust the following year, on 6 April 2017. I note this review, conducted by the Care Manager, identified risks and considered the service user's care needs. I note there is written evidence of C's involvement in this process. I also note the efforts made to listen to the service user's own views, her expressed view being that she preferred to live at home. The review documentation included the following wording:
'[The service user] will stay at home for the foreseeable future . . . '

65. I am satisfied from this review that consideration was given to the service user's best interests. However, I note the complainants were not given an opportunity to contribute to the review, nor to the conclusion reached that the service user would remain at home for the foreseeable future. The Trust said:
'There is no documentary evidence of this contact between the complainants and the Trust' . . . In hindsight the Trust recognises that particularly where family dynamics are contentious, it is good practice to obtain all viewpoints.'
I consider the Trust failed to adequately involve A and B by failing to give them

an opportunity to contribute when their mother's best interests were being considered in April 2017.

Assessment August 2017

66. I note the service user's care needs were reviewed again by the Trust four months later on 15 August 2017. It is not clear why this review was undertaken. However I note that, one day before the review, sister A sent an email to the Care Manager listing several concerns about the care being provided to her mother by C. The email included the following:
'We receive no communication or support from the Trust. It is clear that this family needs a new Care Manager – one that all the family can communicate with and one that is willing to listen to all of us. Fundamentally, one that will enable us to make important informed decisions in regard to our mother's welfare.'

67. I note the review, conducted by the Care Manager, identified risks and considered the service user's care needs. I note there is written evidence of sister C's involvement in this process. I also note the efforts made to listen to the service user's own views, her expressed view being that she preferred to live at home. The review documentation included the following wording:
'[The service user] is very happy in her own home – was asked if she wished to go to a Residential Home either here or Scotland. She confirmed she wished to stay in her own home. [C] is also happy with the care provided by [business name redacted]. She would agree that [the service user] is happy and content in her own home and the package of care is working well.'

68. I note the Care Manager gave sister A a written update (by email) of action taken following the review. His email, sent on 15 August 2017, included the following:
'I hope this goes some way to reassuring you that [your mother's] care needs are being reviewed to hopefully meet her needs while trying to keep her as independent as she likes to be.'
This contact with A, albeit in response to her written concerns, is noted. I am satisfied from this review that consideration was given to the service user's best interests. However, I note that once again the complainants were not given an

opportunity to contribute their view, in particular to the conclusion reached that the service user would remain at home. I consider the Trust failed to give sisters A and B an opportunity to contribute when their mother's best interests were being considered in August 2017.

Misleading correspondence

69. I note the Psychiatrist IPA's advice that, *'in a progressive neurodegenerative disease such as Alzheimer's Disease it would be unusual for a patient to regain capacity.'* I accept this advice. I was therefore surprised to find that two years after the Consultant Psychiatrist's report, the Trust's final written response to the complaint, dated 17 April 2018, indicated that the service user still had capacity:
'I understand that your mother has told hospital and community professionals that she does not wish to live in Scotland on a permanent basis. This can of course be kept under review should her views change or in the event that she is considered not to have capacity, should this be considered to be in her best interests depending on her assessed need.'

70. In response to my office the Trust said:
'The Trust accepts that the statement regarding [the service user] having capacity was misleading and objectively incorrect . . . and apologises for any distress or confusion this may have caused.'
I consider this misleading comment about the service user's capacity, made in the Trust's final written response to the complaint, a complaint which focussed on the issue of capacity, constitutes further failure in the Trust's handling of the complainants' concerns about the service user's capacity.

Summary of findings

71. I found the Trust appropriately managed the service's user's capacity prior to March 2015. I found the Trust failed to act upon a referral by an OT for a psychogeriatrician assessment in March 2015. I found the Trust failed to give sisters A and B an opportunity to contribute when their mother's best interests were being considered in June 2016, April 2017 and August 2017. The Trust also made a misleading statement to A and B regarding their mother having

capacity in April 2018. I consider these failures were in breach of the first principle of good administration *'Getting it right'* and, constituted maladministration which caused the complainants the injustice of uncertainty, frustration and loss of opportunity to have input into discussions about their mother's best interests, including where her needs would be best met.
I therefore partially uphold this element of the complaint.

72. I shall address the issue of the sharing of information with sisters A and B in the next section.

b) Conduct of Care Manager

Evidence Considered

Legislation/Policies/Guidance

73. I considered the following policy and guidance:
    - NICE CG42
    - NICE CG136; and
    - NMC Code 2015.

Trust's response to investigation enquiries

74. The Trust said:
'[Sister C] was the only family member living in Northern Ireland, and could be considered as [the service user's] nearest caring relative. She lived locally to her mother and maintained regular contact with the Care Manager in regards to her mother as and when necessary.
[The Care Manager] listened to the opinions of all family members and was aware of the difficulties they both reported regarding their relationship. [The Care Manager] sought to be balanced and impartial in all of his dealings with the family.'

75. The Trust said:
'[The Care Manager] was aware of the family dynamics and as such he did endeavour to communicate with all relative parties, albeit this may not always have been documented.'

Relevant Trust records

76. The following Trust records were considered:

- Email from Care Manager to C, 7 November 2013
- Email from Care Manager to C, 16 March 2015
- Email from Care Manager to C, 18 March 2015
- Email from Care Manager to C, 2 September 2015
- Email from C to OCP[8], 6 April 2016
- Email from Care Manager to B, 23 November 2017
- Emails from Care Manager to A, 14 and 15 August 2017
  Relevant extracts are contained in the Care Manager IPA report at Appendix four.

Relevant Independent Professional Advice

77. The Care Manager IPA advised:
'There was a failure from the outset to set out a core, initial agreement of the terms of engagement and communication between the Trust and all three daughters (together and as individuals) in terms of care planning, review and care planning decisions about the service user's care management. This amounts to a departure from national guidance ie NG97, QS184, and CG136 with reference to involving and engaging with carers/family.'

78. The Care Manager IPA listed several *'core assessments, specialist assessments and care plan reviews'* and advised the following:
'Although the above care planning, review and assessment documents include reference to the roles and responsibilities of daughters A and B it would seem (according to daughters A and B complaints) that these documents were not shared with them. This amounts to a departure from national guidance ie NG97, QS184, and CG136 with reference to involving and engaging with carers/family.'

79. The Care Manager IPA advised:
'The Care Manager fulfilled, overall, his role in line with professional standards

[8] Office of Care and Protection

of practice and behaviour and in line with national guidance. He made some mistakes/lapses or errors of judgement when engaging with daughter C.'

80. The Care Manager IPA advised:

'The Code (NMC, 2015) says that a Registered Nurse must: . . .stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers.'

He added: *'The use of informal and/or overly-friendly language that implies criticism of another family member is clearly to be avoided and very likely to cause problems if it's not.'*

Other information considered

The complainant's response to the draft report

81. The complainants said:

'By withholding the report[9], and with the inclusion of sister C in further discussions, particularly around risk, the family problems were further exacerbated to the point that relationships entirely broke down and, as a consequence of that, the relationship with the Care Manager became untenable. This is hugely significant.'

'The withholding of such crucial information, that which directly related to what was causing family disagreement wasn't mere oversight or a 'missed opportunity', rather, it demonstrates the Care Manager actively and maliciously excluding family members to favour his own entrenched position in favour of the other family member.'

82. The Trust said:

'The Trust is pleased that the care manager's focus on [the service user's] best interests and wishes in the face of an acrimonious family dynamic is recognised. The Trust would like to emphasise that the care manager was continually engaging with family members and negotiating how information was shared, and does not fully accept that family members were uncertain as to what was happening in relation to [the service user's] care. When [the service

[9] Second psychiatric report, 2 June 2016

user] had capacity, the care manager is of the view that she chose to involve C in her care decisions as opposed to other family members and the care manager may have continued to be influenced by this. The Trust accepts, however, that any perceptions of uncertainty or lack of communication may have been addressed if, from the outset, the Trust had sought to formally clarify and confirm a core, initial agreement with all three daughters of the terms of their engagement and communication regarding sharing information of care planning.'

83. The Trust said:
'The Trust acknowledges that while the care manager sought to be professional at all times and to involve all family members, geographical proximity meant that he often engaged more closely with C. Recognising the challenge that family tensions and critiques of practice brought to the care manager's role, the Trust accepts that there were some incidents where family members may have perceived a bias of communication, and is sorry for any undue distress this may have caused.'

Analysis and Findings

84. Caring for an elderly parent who is living with dementia can be very challenging and stressful for the immediate family. The pressure put on sibling relationships is one aspect of this because agreement on what care arrangements work best cannot always be reached. While the Trust's primary responsibility is to the individual in need of care, invariably this means working alongside the immediate family, particularly when the service user lacks capacity and decisions need to be made in the service user's best interests.

85. I consider the Care Manager role is an impartial interface between the Trust, the service user and their immediate family. The post holder must be relied upon to take decisions based on objective analysis. I consider the role to be of particular importance when the relationship between key family members has broken down. It is likely the role would come under particular scrutiny when, perhaps unavoidably, the views expressed by the Care Manager align with the perspective of one family member. The Care Manager IPA advised that the

Care Manager in this case had a difficult task given the acrimonious family dynamic. I accept this advice.

86. I note the Care Manager emphasised on several occasions that the service user's care provision was his focus. There is evidence of care assessments being conducted by the Care Manager and these involved various decisions being taken by the Care Manager to address particular care needs. This included consideration of the service user's capacity and where, in her best interests, she should reside. I note the Care Manager IPA was not critical of the care provided to the service user by the Care Manager. I accept this advice.

Core, initial agreement

87. *According to the first Principle of Good Administration: 'Public bodies must act in accordance with recognised quality standards, established good practice or both . . .'* I note and accept the Care Manager IPA advice that a core, initial agreement with all three daughters of the terms of their engagement and communication regarding sharing information of care planning was not evident from the outset. I am satisfied this was a failure to apply the relevant guidance, for example, paragraph 1.1.15 of CG136:
If the person using mental health services wants their family to be involved, encourage this involvement and:
    - *negotiate between the service user and their family or carers about confidentiality and sharing of information on an ongoing basis*
    - *explain how families or carers can help support the service user and help with treatment plans*

I consider this failure caused A and B the injustice of uncertainty, frustration and anxiety in their role as carers for their mother.

Communication with family

88. I note the Care Manager IPA found an inconsistency in how information was shared with the family which he attributed to the Care Manager's failure to establish a core, initial agreement with the daughters. In particular, I note the IPA did not find evidence that care plans were shared with daughters A and B,

contrary to the established guidance[10]. I accept this advice. Taking account of the significance of sister A's role, I consider this represents a failure to follow the first Principle of Good Administration, '*Getting it Right',* which requires that: *'Public bodies must act in accordance with recognised quality standards, established good practice or both . . . '*
I am satisfied this failure caused the injustice of lost opportunity to engage in the decision-making process for their mother's care. I also appreciate it had the potential to inflame sibling relations which I note the complainants alluded to in their response to the draft report.

89. According to the fourth Principle of Good Administration:
People should be treated fairly and consistently, so that those in similar circumstances are dealt with in a similar way. Any difference in treatment should be justified by the individual circumstances of the case.

90. I found evidence of the Care Manager's communication with all three siblings though I note he communicated primarily with sister C. I note the Care Manager IPA advised that more regular engagement with C would be expected given her proximity to the service user. I further note from the Trust's response to the draft report that: *'When [the service user] had capacity, the care manager is of the view that she chose to involve C in her care decisions as opposed to other family members and the care manager may have continued to be influenced by this.'* However, I also note the examples listed by the Care Manager IPA which show efforts were made by the Care Manager to correspond with sisters A and B to update them in relation to ongoing care issues that were being addressed. I accept this advice and consider it validates the Trust's comments made in response to the draft report in relation to the efforts made by the Care Manager in that regard. I consider there is therefore evidence of steps taken by the Care Manager to engage with all three siblings appropriately. I refer to the IPA report for details of the specific written communications.

91. However, I consider this was not the full picture. I note the Care Manager IPA

[10] CG136,

highlighted areas of the Care Manager's communication which he advised did not meet the professional standard expected of an impartial service provider. I was concerned to find a *'tone and language'* used on some occasions with sister C which the IPA advised *'undermined'* the Care Manager's responsibility to maintain professional boundaries with the three siblings. For example, I note the Care Manager shared with C that sisters A and B had complained about him which the IPA advised was not appropriate. I listed all of the references to the communication examples highlighted by the IPA in the '*Relevant Trust records'* section above. The IPA advised that these communications could be interpreted as the Care Manager being biased in favour of sister C. I note the IPA referred to paragraph 20.6 of the NMC Code (2015):
'Stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers.'

92. I note the complainants believed the Trust acted with *'unfairness, bias and prejudice'* towards them. The Oxford Dictionary definition of bias describes it as an *'Inclination or prejudice against one person or group, especially in a way considered to be unfair.'* I am not persuaded the Care Manager acted in such a manner towards sisters A and B. Rather, the examples highlighted point to a poor handling of communications with the parties. It is important to consider the distinction between actual bias and perceived bias. I consider the complainants perceived they were subject to bias in this case. In its response to the draft report, I note the Trust acknowledged and regretted *'that there were some incidents where family members may have perceived a bias of communication'.*

93. I note the IPA advised that the incidences which he identified *'were of a minor nature and did not breach professional standards of behaviour and conduct.'* I acknowledge the challenging role this case presented for the Care Manager and note there are examples of good written communications as highlighted within the IPA report. However, on balance, I consider the evidence of poor communication, also highlighted by the IPA, is a failure to comply with the fourth Principle of Good Administration. I am satisfied this caused the

complainants the injustice of being treated unfairly in comparison to their sister, C. I therefore partially uphold this element of the complaint.

c) Timing of placement in 2018

Evidence Considered

Legislation/Policies/Guidance

94. I considered the following guidance:

- NICE NG27.

Trust's response to investigation enquiries

95. The Trust said

'[The service user] was admitted to the Ulster Hospital on 31 January 2018 with a fracture, transferring to the Downe Hospital on 17 February 2018 and was assessed as being medically stable for discharge on 21 February 2018. [The service user] was transferred on 23 March 2018 to a rehabilitation bed in [Care Home Two]. Unfortunately there are some occasions when it is difficult to secure the most suitable discharge option for a patient who is assessed as ready to leave an acute hospital bed. The Trust apologises if family considered the duration of time in hospital was too lengthy while a suitable placement to meet [the service user's] needs was sought. The Trust understands that during this period the family were actively exploring nursing homes within Northern Ireland in partnership with the Hospital Social Worker . . .

The Trust has no evidence to support that remaining in hospital for this period of time was detrimental to [the service user's] wellbeing and it afforded the family the opportunity to view and choose an interim placement for their mother.'

Relevant Trust records

96. I considered hospital records provided by the Trust for the period 18 January to 23 March 2018, including the social work file.

97. The Trust records contain the following key dates:

31 January 2018 - admitted to Ulster hospital with a hip fracture;

17 February 2018 – transferred to Downe hospital for rehab;

21 February 2018 - assessed as being medically stable for discharge;
23 March 2018 - transferred to rehabilitation bed in private nursing home.

Relevant Independent Professional Advice

98. The Care Manager IPA advised:
'In the [service user's] case, I can see again that much of the correspondence centred on the disagreement between the siblings and the desire to move her to a nursing home in Scotland from two of the daughters which was opposed by the other daughter.
The time taken was not attributable to any failure by the care management team, but rather that arrangements for ongoing suitable care are difficult to organise and several factors have to be considered, including acceptability to the individual and to the main carer.'

99. The Care Manager IPA advised:
'It is normal practice to seek the views of an individual about their choices and wishes, including when there are issues of mental capacity. Even when an individual lacks capacity to weigh up information, to assess risks and benefits, and then come to an informed decision, they still may be able to express their wishes in terms of favouring one option over another. It may be justifiably considered that they are not capable of reaching a decision or making an informed choice, and one that is the safest option, but nevertheless their views remain valid and should be heard.
Listening to, and honouring, an individual's wishes is a fundamental aspect of providing care and advocating for the interests of an individual with limited, or lack of, capacity.'

Analysis and Findings

100. In January 2018, I note the service user had a fall at home which resulted in the fracture of her right hip. I note that *'a permanent placement in a Scottish care home was offered repeatedly'* by the complainants both before and after this unfortunate accident. The complainants were clear that a placement in Scotland was immediately available. However, I note their mother was kept in hospital and the Trust sought to identify suitable care home accommodation in

Northern Ireland.

101. There is no suggestion in the complaint that the time spent in hospital between 18 January and 21 February 2018 was unreasonable or inappropriate. The Trust indicated the service user was not medically fit for discharge until 21 February 2018 and I have no reason to doubt this was accepted as fact by the complainants. I therefore considered the four-week period between 22 February and 22 March 2018 (inclusive) to be the extent of the period of delay referred to in the complaint. Correspondence between the complainants and the Trust during March 2018 also makes this clear.

102. In March 2018, I note the complainants raised concerns about the length of time the service user had remained in hospital and the detrimental effect this was having on her care. I note the service user *'declined OT, Physio and refused to eat. Her strength began to fail and she lost a staggering amount of weight.'* It is unfortunate the service user did not engage well with the care provided while she was recovering in hospital. There was no suggestion in the complaint that the hospital care was deficient. Rather, the complainants believed the time taken to find a care home led to a decline in their mother's condition. I note the complainants were frustrated because their mother was 'self-funding' and a care home in Scotland was readily available to provide the necessary accommodation.

103. I note the service user was approached in hospital and asked if she wanted to live in Scotland, an approach which the complainants considered to be *'clumsy and extraordinarily insensitive'* since, according to the complainants, *she 'was in no way capable of understanding the consequences of her response, and predictably stated that she wanted to go home'*. I addressed the issue of capacity earlier in this report. I accept the Care Manager IPA's advice about the importance of seeking the service user's preferences and wishes, even where they lack capacity. I therefore do not consider the approach was unreasonable.

104. I note the Care Manager IPA acknowledged the challenges of establishing

ongoing care for someone with a level of need similar to the service user at that time. I note the IPA advised this can cause delay in patient discharge from hospital. Although the elderly parent was fit for discharge on 21 February 2018 she was not discharged for a further month. I accept the IPA advice that this timescale did not point to a failure by the care management team.

105. I note the placement in a care home in Northern Ireland on 23 March 2018 was accepted by all three siblings. I consider this acceptance facilitated progress towards permanent placement.

106. I note the complainants highlighted a *'misunderstanding'* by *'a member of the Trust staff'* in relation to the facilities in the eventual care home which hindered the service user's initial placement. I note paragraph 1.1.4 of NG27 highlights the importance of communication and information sharing with a service user's carers *'to ensure the transition is co-ordinated and all arrangements are in place.'* Whilst the misunderstanding may raise a doubt over the level of attention paid to communication and information sharing on this occasion, I note the investigation identified that placement was delayed by two days, a period which is not considered significant when measured in the context of the overall transition process.

107. I did not find evidence of unreasonable delay in the placement of the service user in a care home following her second hip fracture. I therefore do not uphold this element of the complaint.

CONCLUSION

108. I received a complaint about the care provided by the Trust to an elderly lady living with dementia whose capacity was disputed by two of her three daughters. The complainants said:
    - *'the Trust showed clear unfairness, bias and prejudice which ensured avoidable delays, leading directly to [their mother's] death.'*
    - *The Trust 'routinely claimed [their mother] . . . had capacity to make vital decisions about her further care.'*

- their *'repeated requests for assessment [of their mother] by an expert geriatric psychotherapist were ignored in favour of inexpert assessment from the insufficiently qualified.'*
- their mother's Care Manager *'acted with, and was manipulated by, [their estranged sister].'*

109. I found the Trust failed to act upon a referral for a psychogeriatrician assessment; and failed to adequately involve the complainants after a subsequent psychiatric report established their mother lacked capacity to decide where she should live. I also found examples of poor communication and information sharing by the Care Manager which undermined his impartiality amidst the volatile family dynamic in which he was providing a service. I partially upheld the complaint.

110. I am satisfied that the failures identified caused the complainants to experience the injustice of loss of opportunity, uncertainty, frustration, anxiety and annoyance as they tried to play their part in the care of their mother while living at a distance in Scotland.

Recommendations

111. I recommend that the Trust provides the complainants with a written apology in accordance with NIPSO *'Guidance on issuing an apology'* (June 2016), for the injustice caused as a result of the failures identified within **one month** of the date of this report.

112. I note the Care Manager referred to in the report is now retired. However, for service improvement and to prevent future recurrence, I recommend care management staff be reminded of the significance of their role, with particular reference to the issues highlighted in this report, namely:
    - handling difficult family relationships;
    - the value of agreeing terms of engagement with family members;
    - sharing information; and
    - the importance of impartiality.

113. I recommend that the Trust implements an action plan[11] to incorporate these recommendations and should provide me with an update within one month of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies).

114. I note the Chief Executive of the Trust has accepted my findings and recommendations.

MARGARET KELLY
Ombudsman **20 August 2021**

[11] I note the Trust provided an action plan within its response to the draft investigation report.