London Borough of Haringey (19 003 309)

Category : **Adult care services > Assessment and care plan**

Decision : **Upheld**

Decision date : **17 Jan 2020**

The Ombudsman's final decision:

Summary: Mrs X complains about the Council's involvement in finding her adult son a community placement to enable his discharge from hospital, where he had to live for around three months without the deprivation of liberty safeguards being properly applied. The Ombudsman found fault in how the Council communicated with Mrs X and her son its search for his community placement. It was also fault for it not to authorise his deprivation of liberty safeguards much sooner. The identified fault caused a significant

injustice to Y and Mrs X, and the Council accepted the Ombudsman's recommended remedy.

The complaint

1. Mrs X complains about the Council's involvement in decisions made about her adult son's care. In particular, she is unhappy about delays in finding him a community placement so he could leave hospital after a detention order ended. She says the Council then failed to apply the deprivation of liberty safeguards correctly and says he was held unlawfully. Mrs X says the hospital environment was completely unsuitable for her son and the extended time he spent there caused him significant avoidable distress.
2. Mrs X also says although the Council responded to her complaint about this, it did not ask a suitably independent person to carry out its investigation.

Back to top

What I have investigated

3. I have investigated events in this case from around October 2017. That is when Mrs X's son was detained in hospital under the Mental Health Act 1983. I have chosen then as it is key point in a long chain of events. I considered Mrs X's comments inviting me to investigate further back. I explain my reasons for not doing so at the end of this statement.
4. In this case, Mrs X's son was under the care and supervision of the Haringey Learning Disability Partnership (HLDP). It is a 'integrated multidisciplinary service' made up of staff from two NHS trusts and the Council. The Ombudsman's jurisdiction extends only to councils and so, in this case, while I can investigate the actions of the HLDP, I can only do so where they acted to discharge the Council's responsibilities. Any clinical decisions are outside of our jurisdiction. For avoidance of doubt, I will refer to 'the Council' below but that includes the HLDP.

Back to top

The Ombudsman's role and powers

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. We may investigate a complaint on behalf of someone who cannot authorise someone to act for them. The complaint may be made by:

- their personal representative (if they have one), or
- someone we consider to be suitable.

7. (Local Government Act 1974, section 26A(2), as amended)
8. We investigate complaints about 'maladministration' and 'service failure'. In this statement, I 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. I 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)
9. We cannot question whether a council's decision is right or wrong simply because the complainant disagrees with it. We must consider whether there was fault in the way the decision was reached. (Local Government Act 1974, section 34(3), as amended)
10. If we are satisfied with a council's actions or proposed actions, we can complete our investigation and issue a decision statement. (Local Government Act 1974, section 30(1B) and 34H(i), as amended)

Back to top

How I considered this complaint

11. I spoke with Mrs X and considered her complaint correspondence with the Council and the Ombudsman. I wrote to the Council to make enquiries and reviewed the information it sent in response.
12. I have taken into account relevant sections of the Code of Practice in this area. It is called, 'Mental Capacity Act, Code of Practice: Deprivation of Liberty Safeguards'.
13. I shared my draft decision with Mrs X and the Council and I invited them to comment on it.

Back to top

What I found

14. Mrs X brought this complaint to the Ombudsman on behalf of her adult son, who I will refer to as Y. It suffices to say Y has learning difficulties because of a lifelong disability. As an adult he has lived both at home and in supported living accommodation. While I will refer mainly to Mrs X in this statement, it is important to highlight her husband Mr X has also had close involvement on many occasions in advocating for Y.
15. By September 2017 Y's situation saw him in an increasing state of distress. Mr and Mrs X tried to draw professionals' attention to this. A 'Care and Treatment Review' meeting took place in October 2017 and, because of Y's behaviour that day, he went to hospital and later on professionals detained him under the Mental Health Act. He first went to a local hospital but later moved to a hospital outside the immediate area.
16. Section 2 of the Mental Health Act 1983 allows a maximum of 28 days detention for treatment. Mrs X says she believed plans would be in place for Y to move back into the community at the end of that period. It in fact took until late April 2018, and appearances at the Court of Protection, for Y to leave hospital.

Finding Y a community placement

17. Discussions about finding a placement for Y were already taking place before his admission to hospital. Soon after his admission, in early November 2017, there was a meeting where Y's social worker was tasked to update on any progress towards finding a placement for him.
18. The Council has a responsibility for finding Y a placement. It has a list of approved private providers and uses a 'brokerage' process where they bid for a contract once the Council advertises a client's requirements. Once it finds a suitable provider the case goes to a Council panel to agree whether the placement is acceptable and to sign off the cost.
19. The Council's records suggest around the end of November three private providers came forward in response to the request made by the Council's brokerage team. While his Mental Health Act detention was no longer necessary, professionals agreed he should stay in hospital while the Council arranged a new placement.
20. The Council's evidence shows the role of viewing and assessing the providers and their properties was left to clinical staff on the HLDP. In doing this they were exercising the Council's social care function and responsibilities. It was around this time assessments were arranged where the providers could meet Y to enable them to tailor their quotations and plans accordingly. Y and Mr X attended some of the visits.
21. The Council received the first quotation in early December. During that month, further visits to place to some properties of interest. A clear assessment took place of their suitability for Y and some were removed from consideration. There is no evidence Y's social worker had any direct involvement at this stage while others from the HLDP took the lead.

22. Mr and Mrs X expressed concerns throughout this time about the Council's approach. By early January the Council identified a favoured location, which Provider 1 put forward. Provider 1 was in the process of buying the property, but it was also subject of interest from a competing provider. The Council said it would not commission Provider 1 until it was clear who owned the property and viewings took place elsewhere in January.
23. Provider 1 then sent quotations to the Council for two locations. The Council considered the cost to be high and expressed concern plans for Y's care missed key information. For example, a risk assessment document was 'too vague'. The clinical staff challenged this and gave advice to Provider 1. Despite this, the case still went to the panel, but it rejected it due to cost and because of the incomplete plans. The panel also considered, and rejected, an interim placement elsewhere as it believed it would "be disruptive to Y's recovery" and there was not a "robust and safe support plan" in place.
24. In mid-January 2018 the clinical staff received advice from the Council's brokerage team Provider 1's costs were still too high and to consider other options. However, given Y's strong preference for Provider 1's property, meetings continued with it to try to improve its submission and reduce costs.
25. Around this time Mrs X expressed strong reservations about the viability of considering other options, given Y was so attached to his favoured choice. There is evidence clinical staff spoke with Provider 1 again and this resulted, in February, in reduction of around £1,000 per week from the previously quoted fees. However, when the case returned to the panel, it again refused the placement because of the cost. The panel asked for other options to be considered and documented.
26. A full review meeting about Y's case took place in March 2018. The aim was to tell Y his preferred placement with Provider 1 would likely not happen. By this time Mr and Mrs X had instructed solicitors to act in Y's interests and proceedings in the Court of Protection had started.
27. In April 2018 a 'round table' meeting took place, attended by the various parties under the supervision of and as directed by the Court. This resulted in an agreement for Y's parents to pay a weekly top up fee to enable him to move to his preferred location with Provider 1. In this meeting the Council accepted Y had been shown around Provider 1's property at a time it knew it was too expensive. It said it had hoped it would negotiate more.

Deprivation of Liberty Safeguards

28. The Deprivation of Liberty Safeguards (DoLS) came into force in April 2009. The safeguards provide legal protection for individuals who lack mental capacity to consent to care or treatment and live in a care home, hospital or supported living accommodation. They protect people from being kept somewhere against their will, unless it is in their best interests and there is no less restrictive alternative. The law sets

out the procedure to follow to get authorisation to deprive an individual of their liberty. Without the authorisation, the deprivation of liberty is unlawful.

29. In this case, it was the hospital's responsibility to apply for authorisation. The Council was the supervising authority, even though Y was outside its area. On application, the supervisory authority must carry out assessments of the six relevant criteria: age, mental health, mental capacity, best interests, eligibility and 'no refusals' requirements. A minimum of two assessors, usually including a social worker or care worker, sometimes a psychiatrist or other medical person, must complete the six assessments. They should do so within 21 days, or, where an urgent authorisation is already in place, before the urgent authorisation expires.
30. The Council granted an urgent authorisation in this case on 21 November 2017. The hospital made a standard application at the same time. There followed a significantly delayed response from the Council, meaning Y's DoLS was not in place between 29 November 2017 until 20 February 2018. This means Y was not covered by the DoLS during that period as it could not be backdated.
31. The Council says it follows the nationally agreed procedure for DoLS. When Mrs X complained it told her it had issues finding a Best Interests Assessor (BIA) and had to commission an external company to carry out the work. It did this around four weeks after it received the initial application. The BIA then visited Y at the hospital on 30 December but took until 20 February 2018 to send her report to the Council. It says the external company then failed to provide the psychiatrist it previous promised. The Council says it reallocated Y's case on 12 February, received the psychiatrist's report a week later and then issued the DoLS the following day. While the Council accepts it was at fault for the time taken, it says this was a technical breach and so caused no significant injustice to Y.
32. Mrs X takes the opposite view. She believes the failure to authorise Y's DoLS meant he stayed in hospital longer than he otherwise would have. Mrs X suggests evidence for this can be found in the Best Interests Assessor's report. She also says Y had his more general rights afforded under DoLS taken away and could not challenge it because she was unaware the Council had appointed her as Y's representative.

Complaint investigation

33. When Mrs X complained to the Council it tasked a manager from the learning disabilities department to respond.
34. Mrs X says the manager had previous involvement in case and was not independent enough. She does not feel all her points were properly addressed.
35. The Council says while the manager concerned had detailed knowledge of the case, and acted in good faith throughout, it accepts she had chaired meetings with the family and others as directed by the Court of Protection. It accepts this could lead to a perception

of a conflict of interest.

36. However, it says it stands by the overall complaint response and points out it was 'subject of scrutiny and approval by the Assistant Director' who was not involved in the case, before being sent.

Back to top

Analysis

37. While the Ombudsman investigates whether there is fault in a decision or action taken by the Council, officers are entitled to use their training and experience to make professional judgements. While it is understandable Mrs X may disagree with the Council's actions, we cannot find fault with a properly taken decision.

Finding Y a community placement

38. Mrs X explains in her complaint her concerns about the hospital environment and the effect it had on Y. While it was a clinical decision for him to be in hospital, and so outside our jurisdiction, a stay prolonged by fault on the Council's part could add significantly to the injustice caused.
39. It is not fault for the Council to refuse potential placements for Y on the basis they cost too much. It can fully consider cost in making such decisions.
40. Overall, there is evidence efforts were made over several months to find a placement for Y. The Council accepts the time taken was unsatisfactory, but I cannot attribute the delay to the Council's actions alone. It was reliant on private suppliers to bid, and Y's favoured provider to send information needed for risk assessments and support plans. Most of what I have seen suggests the Council applied its usual process and faced issues getting the preferred supplier to provide the information required to get through the panel. It was not simply a matter of cost.
41. However, there was a significant problem with communication and raised expectations in this case. The Council was often unable to fully explain to Mrs X what was happening in finding a placement for Y. On balance, I conclude it raised Y's expectations about

frustration, particularly to Y but also Mrs X and Mr X.

Deprivation of Liberty Safeguards

43. The question put forward by Mrs X in bringing the complaint is whether the failure to put

in place a DoLS for Y was technical or substantive. The Ombudsman cannot answer in those terms. We investigate whether there was fault and, if there was, if it caused any personal injustice. However, it could be said a technical breach of the law is approximately the same as fault where no injustice is caused.

44. There was undoubtedly fault in respect of DoLS in this case. The Council took much too long to assess Y and put in place the authority sought by the hospital. There were problems in finding a suitable BIA and then a failure to chase up the their report in a timely manner. The DoLS Code of Practice says, "assessments must be completed within 21 days for a standard DoLS". There was significant and unacceptable drift in this case far beyond 21 days. While some of the evidence I have seen explains why it happened, it does not justify it.
45. I am satisfied this caused a significant injustice to Y as a result. The Council's failure deprived him of his rights, particularly to challenge his stay at hospital. On balance, and considering what happened later, I think his parents would have acted on Y's behalf if they had understood DoLS in the way they only did once the Council authorised it in February 2018. I do not think it is unreasonable to assume they would have approached the Court of Protection sooner.
46. However, I cannot accept Mrs X's main claim the failure to put the DoLS in place contributed to Y's continued detention in hospital. I have read the BIA report. It explained reasons Y might have been at risk of harm and so should not be free to leave the hospital. However, that confirmation was necessary to address the specific legal requirements of DoLS. I am satisfied Y would have remained at the hospital whether his DoLS was in place or not. There is no evidence the process around Y's DoLS application had any impact at all on the Council's approach to finding a community placement for him.

Complaint investigation

47. The Council's decision to appoint a manager not sufficiently independent of the case to investigate Mrs X's complaint was fault.
48. However, I cannot see this caused any injustice to Mrs X. The response the Council sent was suitable both in content and tone. The letter was also subject to approval from a director before Mrs X received it.

Back to top

Agreed action

49. By 17 February 2020, the Council has agreed to:

    - Apologise to Mr and Mrs X for any uncertainty and frustration caused by the Council's failure to properly manage Y and his parent's legitimate expectations, and the unacceptable delay in authorising his DoLS.
    - Remind all senior managers of the need to ensure they excuse themselves from investigating complaints if they have had any significant involvement in the events subject of the complaint.

50. By 17 July 2020, the Council has agreed to:

    - Carry out a senior level management review of the current timescales to process DoLS applications and clearly identify any issues, including with timeliness. Then put in place an action plan to address them.
    - This should include a much more robust process for monitoring timeliness in cases where the Council has to commission external assessors.

51. The Council should update the Ombudsman when it has completed these actions.

Back to top

Final decision

52. There was fault in the Council's communication with Mrs X and Y when it was searching for a community placement for him. There was also fault when it delayed authorising a DoLS application for Y.

Back to top

Parts of the complaint that I did not investigate

53. My initial conclusion was Mrs X could have complained to the Council sooner about Y's treatment by it from September 2016 to September 2017. Mrs X gave reasons why she thought I should do so.
54. I note the Council declined to look at the older events and only considered the above complaint, even though it was out of time as well, because of an agreement made in court. Despite the court order suggesting the agreement only extended to the complaint about DoLS, the Council responded about other events during Y's time in

hospital too.

55. We must make our own decision. The law says the Ombudsman cannot investigate complaints about something that happened more than 12 months ago, unless there is good reason to. Mrs X explained why she could not complain sooner. This particularly centred on the serious issues involving Y she prioritised, and I understand why she prioritised that
56. However, I must consider the reliability of the evidence and my ability to test it when three years have passed since some of the events in question. I also believe it will be difficult to achieve a suitable remedy for Y. While Mrs X says the Council's actions contributed to Y's increasingly unsettled behaviour, which culminated in his detention under the Mental Health Act, I think it would difficult for me to reach such a conclusion. Events have moved on significantly since that point and Y has been out of hospital for well over a year.

Investigator's final decision on behalf of the Ombudsman

Back to top

Investigator's decision on behalf of the Ombudsman

Print this page