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PUBLIC SERVICES OMBUDSMAN FOR WALES
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The investigation of a complaint against Gwynedd Council, Betsi Cadwaladr University Health Board and Cartrefi Cymru

A report by the
Public Services Ombudsman for Wales
Case: 201806533, 201806536 and 201806537

Contents

Introduction

This report is issued under s16 of the Public Services Ombudsman (Wales) Act 2005.

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

Summary

Mrs M's son, Mr N, suffered from drug-induced psychosis and acquired brain injury. He received a package of care, funded jointly by Gwynedd Council ("the Council") and Betsi Cadwaladr University Health Board ("the Health Board"), and provided by Cartrefi Cymru ("CC"), a registered domiciliary care provider. Mrs M complained about:

a) the care given to Mr N by CC

b) failings in communication between the Council, the Health Board and CC, resulting in CC not receiving comprehensive documentation/risk assessments/care plans for Mr N.

Sadly, Mr N choked while eating alone in his bedroom, and died despite first aid being administered by his carer.

The Ombudsman found that the Council and the Health Board jointly funded Mr N's care, with the Council being the lead commissioner. However, despite there being an overarching, general contract with CC for the provision of care, there seemed to be no documentation showing the awarding of the contract and the specific terms relating to Mr N, and the respective responsibilities of the parties. This amounted to maladministration on the part of both the Council and the Health Board. In addition, there was no documentation to show that the Council, as lead commissioner, had monitored the delivery of the service under the contract.

Although the Ombudsman could not say with any certainty that any of the bodies had seen a risk assessment relating to the risk of Mr N choking, CC should have carried out its own choking risk assessment in view of Mr N's obvious vulnerabilities.

The Ombudsman upheld the complaint against all three bodies. However, he did not conclude that any of the failings he identified had caused or contributed to Mr N's death. However, Mrs M would be left with the uncertainty that, but for the failings, things might have been different.

The Ombudsman made the following recommendations:

(a) The Council and the Health Board

1. Within **one month** of the issue of the report, both the Council and the Health Board should apologise to Mrs M for the failings I have identified.

2. Within **three months** of the issue of the report, both the Council and the Health Board should review their respective contract governance arrangements to ensure that contract management is in line with good practice (as contained in the Contract Management Principles and the principles in the Wales Procurement Policy Statement).

(b) The Health Board

3. Within **three months** of the issue of the report, the Health Board should remind staff members with responsibility for managing a service user's Care and Treatment Plan and care package of the need to ensure they comply with the requirements of NICE Clinical Guideline CG136 and the Mental Health (Wales) Measure 2010 and the Mental Health Act 1983 Code of Practice.

(c) CC

4. Within **one month** of the final report, CC should apologise to Mrs M for the failing I have identified.

5. Within **three months** of the final report, CC should remind members of staff with responsibility for delivering care plans of the importance of ensuring all relevant assessments are carried out, and the care package reviewed, as soon as possible after being contracted to provide care.

The Complaint

1. Mrs M's son, Mr N, suffered from drug-induced psychosis and acquired brain injury. He received a package of care, funded jointly by Gwynedd Council ("the Council") and Betsi Cadwaladr University Health Board ("the Health Board"), and provided by Cartrefi Cymru ("CC"), a registered domiciliary care provider. Mrs M complained about:

a) the care given to Mr N by CC

b) failings in communication between the Council, the Health Board and CC, resulting in CC not receiving comprehensive documentation/risk assessments/care plans for Mr N.

Investigation

2. The Investigator obtained comments and copies of relevant documents from the Council, the Health Board and CC and considered those in conjunction with the evidence provided by Mrs M. The Investigator took advice from one of the Ombudsman's professional advisers, a Registered Mental Health Nurse and NHS Commissioning Manager with experience of commissioning continuing healthcare packages for individual patients with complex needs. His name is Danny Alba. The Adviser was asked to consider whether, without the benefit of hindsight, the care or treatment had been appropriate in the situation complained about. I determine whether the standard of care was appropriate by making reference to relevant national standards or regulatory, professional or statutory guidance which applied at the time of the events complained about. The Investigator also discussed the question of the procurement of services by public bodies in Wales with an officer of the Welsh Government's National Procurement Service. I have not included every detail investigated in this report but I am satisfied that nothing of significance has been overlooked.

3. Mrs M, the Council, the Health Board and CC were all given the opportunity to see and comment on a draft of this report before the final version was issued.

Relevant legislation

4. Clinical Guidelines ("CG136") issued by the National Institute for Health and Care Excellence entitled "Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services" advises that the care plan should support "effective collaboration with social care and other care providers during endings and transitions".

5. Guidance from the Crown Commercial Service on Contract Management Standards contain Contract Management Principles. The first 3 Principles are:

- Ensure that contracts are known and understood by all those who will be involved in their management.
- Be clear about accountability, roles and responsibilities.
- Establish and use strong governance arrangements to manage risk and enable strategic oversight.

Although it is not a requirement for public bodies in Wales to follow this guidance, the principles contained in it represent good practice.

6. The Wales Procurement Policy Statement (issued by the Welsh Government in June 2015) covers contract management. Public bodies are expected to adhere to the principles contained in the Statement. These include ensuring adequate skills and resources are in place to carry out effective procurement and contract management and ensuring regular contract performance management reviews are conducted.

7. I have issued Statutory Guidance on the Principles of Good Administration and Good Records Management[1] to which public bodies in Wales must have regard when discharging their public functions. I also issued guidance in my Casebook[2] to public bodies in Wales delivering services through arrangements with third parties.

[1] Issued under s31 Public Services Ombudsman (Wales) Act 2005 https://www.ombudsman.wales/guidance-policies/
[2] What's in the postbag? Casebook 31, page 4 - https://www.ombudsman.wales/case-books/

8. The Mental Health (Wales) Measure 2010, and the Mental Health Act 1983 Code of Practice ("the Code"), place legal duties on local health boards and local authorities about the assessment and treatment of mental health problems. In particular, paragraph 34.23 of the Code provides that an assessment of a patient's ability to address their personal care and physical wellbeing must be included in the holistic assessment.

The background events

9. Mr N had a longstanding history of drug and alcohol use; many years before the events in question he sustained serious injuries, including a brain injury, and had several stays in an acute psychiatric unit. A psychiatric report in **1999** concluded that Mr N could have a complex diagnosis of possible obsessive compulsive disorder, substance misuse and alcohol dependence, insulin-dependent diabetes, numerous orthopaedic problems, a brain injury, personality disorder and atypical epilepsy secondary to the brain injury. In **2015** Mr N was living in his own rented home with a package of 24-hour care funded jointly by the Council and the Health Board.

10. Mr N had for some time been involved with the Speech and Language Therapy ("SALT") service because of reported problems with his swallowing and voice. A SALT assessment in July **2015** noted that Mr N tended to overload his mouth, not chew his food properly and eat quickly, which all contributed to coughing episodes when eating. Mr N and his carer were given advice about this, including ensuring meat was tender, lean and moist, and all food was chopped up small. The review of Mr N's Care & Treatment Plan ("CTP") on 30 July referred to him needing "a lot of assistance and advice regarding his food and to encourage healthy eating", but did not mention the swallowing problems or the SALT advice (the reference to assistance and advice seemed to be in the context of helping Mr N manage his diabetes). At a further SALT review in November Mr N's eating problems were reported to be much reduced since the fitting of new dentures and better compliance with the advice given previously. There was no mention of any eating problems/difficulties in the CTP of 20 May **2016**.

11. In January **2016** the company providing domiciliary care for Mr N gave notice to terminate the contract because of difficulties retaining/recruiting staff to work with him. The Care Co-ordinator (at that time a Community Mental Health Nurse employed by the Health Board) made efforts to source

an alternative care provider. However, due to problems identifying a replacement, Mr N moved into a supported housing placement in February while an alternative care provider was identified. The Care Co-ordinator's handwritten records show that CC was contacted by Mr N's father, and that by 22 June the contract had been awarded to CC, with the hope that they would be able to recruit staff and start working with Mr N in August. Sometime in September/October CC staff began shadowing staff in the supported housing placement, and Mr N later moved back to his own home (the records examined by my Investigator do not indicate when this was).

12. During the time Mr N was living in the supported housing placement he was admitted to hospital (on 29 July) following an episode when he choked on his food and a food lump was removed from his oesophagus (the tube which connects the mouth to the stomach). Following this, the Manager of the placement prepared a risk assessment dated 3 August ("the risk assessment"), identifying the risk of choking and providing that staff must cut up food (meat/bacon to be cut into very small pieces) "as [Mr N] tends to swallow without chewing fully". A glass of water was to be available, and "staff must remain close while [Mr N] is eating".

13. At approximately 10:00 on 3 March **2017** Mr N was alone in his bedroom when he choked on a piece of toast. Despite first aid and CPR being administered by his carer, Mr N sadly died.

14. The Record of Inquest of Mr N's death includes the medical cause of death as "choking" and records that the "death was due to an accident".

Mrs M's evidence

15. Mrs M said that CC had "neglected" Mr N while he was in their care, in that they had failed to follow instructions on the care plan following the risk assessment (see paragraph 12). She said that an employee of CC had photocopied the risk assessment while Mr N had been living in the supported housing placement. She said that Mr N's carer did not do enough to help him when he was choking. Mrs M said that Mr N had a lot of complex problems, but that CC did not take account of them all in the team they recruited to work with him.

The Council, Health Board and CC's evidence

Joint response by the Council/Health Board

16. The Council provided a response to the Ombudsman on behalf of itself and the Health Board. It said that the Council and the Health Board jointly funded the package of care for Mr N, and that the Council "agreed to be lead commissioners". It said that CC spent time shadowing the outgoing care provider, and that "all documents relating to [Mr N's] care were shared prior to the transfer of care package". The Council said that the care Managers - an Occupational Therapist, a Community Mental Health Nurse (both employed by the Health Board) and subsequently a social worker (employed by the Council) - monitored the care package and liaised with the care providers, and conducted "several regular reviews over a period of several years".

The Council's evidence

17. In response to further questions the Investigator asked, the Council said that the Community Mental Health Team ("CMHT") was a multi-disciplinary team made up of staff from the Council and the Health Board, and whose members were "in constant contact with each other about service users". It explained the identity of Mr N's Care Co-ordinator at different times. The Council confirmed that the Care Co-ordinator in 2016 (a Community Mental Health Nurse) was the person who identified CC as the new care provider, and that the change of provider was discussed with the Continuing Health Care ("CHC") Team for advice on funding in June 2016.

18. When asked questions about the risk assessment (see paragraph 12) and whether it had been shared with CC, the Council said that "the files are accessible to all members of the CMHT therefore all staff involved had equal access to all the relevant documents and case notes". It said that the risk assessment seemed to have been prepared by the Manager of the placement; it said there had not been a further care plan review between the time of Mr N's admission to hospital and his death, so "there had not been an opportunity to include the risk assessment … in any further care plans". It said it "can be assumed that care plans and any risk assessments contained in [the supported housing placement's] files would have been sent to CC when the care package was transferred". It said that copies of the

SALT assessments (see paragraph 10) were on the social work file, and that the supported housing placement support staff were aware that Mr N could potentially be at risk of harm from dysphagia (swallowing difficulties) when eating.

The Council's response to the draft report

19. The Council confirmed that the contract for Mr N's care had been awarded to CC following contact being made by the Care Co-ordinator with a number of potential providers, without any involvement from the Council's contracts team. It said such commissioning was not unusual within the mental health team, that it was reasonable in view of the urgency of the situation, and that contracts of this kind were excluded from the requirement for a competitive procurement exercise.

20. The Council said the Care Co-ordinator would have been very aware of the need to ensure CC was fully informed of Mr N's needs. It said it could find no evidence that the risk assessment (see paragraph 12) was brought to the Council's attention.

21. The Council said that CC was a longstanding provider of supported housing in the area, and that an overarching contract between the Council and CC was in place at the time for the provision of services, including mental health services. The Council provided a copy of this contract, which included provision for details of individual projects, and the care to be provided, to be included in separate schedules. However, when asked for the relevant schedules, the Council confirmed there were no specific schedules available on file, but referred to entries in case notes and provided invoices as evidence that the contract was awarded to CC. The case notes record that the Care Co-ordinator met representatives from CC who carried out a "brief assessment" of Mr N; CC was to email the Care Co-ordinator costings, which she would pass to her Manager along with others she had received. The next entry records that CC had been awarded the contract.

22. The Council said that it disagreed with the view of the Adviser, and the recommendation that its contract governance arrangements should be reviewed. It said it had introduced a Quality Assurance and Safeguarding

Team in 2017, which had improved its ability to monitor on a routine basis with the focus on quality of care; it said it was considering the need to further increase its staffing capacity within the team.

23. The Council said that the contract management provisions in the Crown Commercial Services guidance (see paragraph 5) were high level principles for all contracts, designed for managing significant contracts for supplies of goods and services. It said that the delivery and quality of care would be monitored by the key worker, who would report back any issues about the standard of care to the Council as their partner.

The Health Board's evidence

24. In response to similar questions the Investigator asked, the Health Board said that Mr N's package of care "would be routinely reviewed as part of a Care & Treatment Planning meeting held between the Care Co-ordinator, the provider and the commissioners". It said that at the time of Mr N's death a planning meeting was being arranged but was delayed as the provider Manager was off sick. The Health Board said that the contract with CC was arranged through a tendering process which included representatives from the Council, the CMHT and the CHC team. It said that payments to CC were made by the Council, with the Council re-charging the Health Board for its agreed share of the cost.

25. The Health Board said that there was no copy of the risk assessment in any of the Health Board records, and there was no mention of it in any subsequent care notes or CTPs. It said that although there was a handover between the supported housing placement and CC, the content of the handover/shadowing was not detailed.

CC's evidence

26. CC said that Mr N's father had first approached CC about providing support for Mr N and that the service was commissioned by the Health Board. It said that the only documentation it had received to enable it to be satisfied it could meet Mr N's needs were:

- A CTP from the CMHT (dated 20/05/15, which was noted to be reviewed by 20/05/16).

- The care plan from the previous support provider (dated 12/10/14).

- A letter from the CMHT (dated 12/04/16, containing a summary of Mr N's history, although it does not indicate to whom it was sent).

27. CC said it had carried out the following risk assessments:

- Assisted living service delivery plan.
- Behavioural management plan.
- Diabetes management.
- Supported living service.
- Medication and wellbeing.
- Stimulant drinks.
- The impact of unhealthy choices on my life.
- Traffic light hospital assessment – in the event of admission to hospital.

28. CC said that the fact that Mr N had "24 hour support" did not mean he would not be left alone in a room. It said that Mr N was entitled to independence and privacy, and that even if a member of staff had been in the room when he choked they would not have been able to dislodge the obstruction. It said there was nothing in the documentation provided to CC to indicate that Mr N had problems swallowing. It said that Mr N's father, who was very involved in Mr N's daily care, had told the Regional Director that there was nothing physically wrong with Mr N. Although a SALT assessment was mentioned in the letter from the CMHT, it said there were no ongoing issues. It said that Mr N would sometimes get up during the night to make himself a snack, or help himself to food during the day; this was consistent with supported living principles where people are encouraged to make choices and live as independently as possible, with staff providing support when needed.

29. CC said that the carer had done everything he could to save Mr N, and had followed the instructions of the 999 operator, only leaving Mr N to check for the arrival of the ambulance crew. It said that an expert witness at the Inquest had concluded that the carer provided the best possible care in extremely challenging circumstances.

30. CC acknowledged that its Transition Plan guidance was not used when setting up the new service for Mr N, and that this was a failing; however, it said this would not have changed the way it supported Mr N when eating. CC said its internal investigation had highlighted areas for improvement in management and quality systems and said that work was ongoing on these.

Professional Advice

31. The Adviser noted that the Council was the lead commissioner, and, together with the Health Board as associate commissioner, jointly commissioned the care package for Mr N. He said such arrangements are common practice, and both the lead commissioner and the associate commissioner are parties to the contract. He said it was the lead commissioner's role to tender the contract and procure the service, and to be responsible for contract monitoring, contract review and contract management. He noted the Council had not produced any tender, procurement or contract documents, or any minutes or notes of any contract review meetings. He said that responsibility for monitoring Mr N's care package as part of the CTP, however, rested with the Health Board.

32. The Adviser referred to guidance from the Crown Commercial Service on Contract Management Standards. The "Principles" listed include ensuring that contracts are known and understood by all those who will be involved in their management, and being clear about accountability, roles and responsibilities. The Adviser concluded that the Council failed to comply with these principles.

33. The Adviser said that because contract delivery was not sufficiently monitored, the Council would not have known whether service provision complied with the contract specification requirements i.e. the care package. If it had been, the Council would have known to what extent the Health Board was managing CC in terms of the CTP and care package and to what extent CC was complying with the contract specification, and how complete the contract specification was (in terms of including previous choking risk assessments, reports, care plans etc). Although it was appropriate for some of the functions (such as the monitoring of the care package and the CTP) to be delegated to the Health Board, ultimately the Council retained overall responsibility and accountability for the contract.

34. The Adviser was concerned that the Council was unable to provide any contract documentation when requested. He said that, from a review of the records, the Council seemed unable to distinguish between contracting practice and managing service provision. He said that, although both are intrinsically linked and dependent on one another, it was the Council's responsibility to manage the contract, and the Health Board's responsibility to manage Mr N's care package. He said both parties should have fully understood their roles and responsibilities.

35. The Adviser said that there was no evidence in the records provided by the Council that it shared contract documentation with the Health Board or CC. It said that there was evidence that the Health Board's Care Co-ordinator [also referred to as the Care Manager] (firstly an Occupational Therapist then a CMHT nurse) carried out the monitoring and review of Mr N's care package. However, he said that the "obvious omission" was the "crucial information" about Mr N's risk of choking on food – in the SALT assessment and reports (paragraph 10) and the risk assessment (paragraph 12). The Adviser said that contract governance was lacking, or misunderstood by the Council, compounded by ambiguous respective roles of the Council and the Health Board. He said that the failure to effectively communicate Mr N's risk of, and propensity for, choking from one agency to another failed to meet CG136.

36. The Adviser noted that neither the review of Mr N's CTP in July 2015 nor that in May 2016 mentioned his swallowing problems or the SALT advice. He said that the information contained in the risk assessment was not effectively passed on to CC, and that as a result the care plan implemented, and CC's support plan based on it, did not make provision for Mr N's risk of choking on food. This meant that the CTP and the care package care plan were not fully in line with the Mental Health (Wales) Measure 2010 Part 2 (specifically Chapter 34 on Care and treatment planning). The Adviser said that it was good practice for at risk/vulnerable service users to have a choking risk assessment carried out and included in their care plan. He said that, even though the information was not passed to CC, CC should have carried out its own assessment based on observations and experience of caring for Mr N and because of his obvious vulnerabilities.

37. The Adviser said that, in the absence of a clear risk assessment and associated care plan/interventions to mitigate the risk of choking on food, there was no reason for Mr N's support worker not to have left Mr N alone when eating. He said that the care provided by Mr N's support worker on the evening of 3 March was in line with principles of good practice, and he had no criticism of the way he looked after Mr N.

38. In conclusion, the Adviser said that there were failings by all parties involved, but he did not believe that these failings contributed to or caused Mr N's death. He said that what happened could still have happened even if there had been better continuity of care and more effective handover of care, and even if CC had carried out a more comprehensive assessment. He emphasised that Mr N was in a home setting with supported living, not a hospital environment, and the principles of encouraging choice, autonomy and self-worth were evident in the support worker's care that evening.

Analysis and conclusions

39. In reaching my conclusions I have taken account of the advice I have received, which I accept in full. The conclusions, however, are mine alone. I would like to take this opportunity to extend to Mrs M my sincere condolences on the loss of her son.

40. In considering this complaint I have been dismayed by the inability of all 3 bodies to provide key documentation. Indeed, it was not until it provided its response to the draft report that the Council told the Investigator that there was an overarching contract in place with CC, and provided a copy thereof. This contract provides for schedules to contain details of individual "projects", contacts and the breakdown of costs for individual service users, but when the relevant schedules for Mr N were requested the Council confirmed that there were no schedules on file. The documentation which I have seen shows that the Care Co-ordinator at the time, a Health Board employee, attempted to identify a suitable care provider for Mr N, but neither the Council nor the Health Board have provided anything to show how the contract was awarded to CC. Although I have seen no evidence to substantiate it, I have no reason to doubt what I have been told – that the Council was the lead commissioner, made the payments to CC and re-charged the Health Board for its agreed share. However, the

apparent lack of any documentation to show the awarding of the contract for Mr N's care, the specific terms in respect of Mr N and the respective responsibilities of the parties amounts to maladministration on the part of both the Council and the Health Board.

41. I am satisfied that it was the Council's responsibility, as lead commissioner, to monitor, review and manage the contract. I was concerned by the failure of the Council to provide any documentation to show that it had effectively monitored the delivery of the service for which it had contracted and for which it was paying. I have seen no notes of any contract review meetings, although the contract had been in existence for some 9 months at the time of Mr N's death. The Council's apparent failure to monitor the contract is maladministration. In contrast, there is evidence that the Health Board monitored and reviewed Mr N's care package.

42. I have received conflicting information about whether the risk assessment was shared with CC, either before or after the contract was awarded. Mrs M has told me that an employee of CC had a copy of the risk assessment, whereas CC told me that it did not. The Council said in effect that it "assumed" CC had been given a copy; the Health Board said there was no copy of it, or any mention of it, in its files, and it had no knowledge of information shared with CC as part of the shadowing process. As the risk assessment was not prepared by any of the Council or Health Board employees, I have no way of knowing whether either body had a copy of it. Neither can I conclude with any certainty whether CC had a copy. However, I do not believe that any of my conclusions depend upon determining this question. I have been advised, and I accept, that CC should have carried out its own choking risk assessment of Mr N in view of his obvious vulnerabilities. I find that the failure to do so amounts to a service failure on the part of CC.

43. I have found maladministration/service failure on the part of the Council, the Health Board and CC. I consider that these failings, taken together, amount to an injustice to Mrs M. I cannot conclude that any of these failings caused or contributed to Mr N's death, as Mr N might still have choked even if none of these failings had happened. However, Mrs M will be left with the uncertainty of not knowing whether, but for these failings, things might have been different and the incident might not have happened.

44. For these reasons, I **uphold** the complaint against the Council, the Health Board and CC.

Recommendations

45. I make the following **recommendations**:

(a) The Council and the Health Board

46. Within **one month** of this report, both the Council and the Health Board should apologise to Mrs M for the failings I have identified.

47. Within **three months** of this report, both the Council and the Health Board should review their respective contract governance arrangements to ensure that contract management is in line with good practice (as contained in the Contract Management Principles and the principles in the Wales Procurement Policy Statement).

(b) The Health Board

48. Within **three months** of this report, the Health Board should remind staff members with responsibility for managing a service user's Care and Treatment Plan and care package of the need to ensure they comply with the requirements of CG136 and the Mental Health (Wales) Measure and the Code.

(c) CC

49. Within **one month** of this report, CC should apologise to Mrs M for the failing I have identified.

50. Within **three months** of this report, CC should remind members of staff with responsibility for delivering care plans of the importance of ensuring all relevant assessments are carried out, and the care package reviewed, as soon as possible after being contracted to provide care.

51. I am pleased to note that in commenting on the draft of this report **Betsi Cadwaldar University Health Board and Cartrefi Cymru** have agreed to implement these recommendations.

Nick Bennett 23 January 2020
Ombudsman

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