

# Six lives: the provision of public services to people with learning disabilities

Part five: the complaint made by Mrs Keohane

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## Second report

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## Section 1: introduction and summary

1 This is the final report of our joint investigation into Mrs Keohane's complaints against Buckinghamshire Hospitals NHS Trust (the Trust), Tower House Surgery (the Surgery), Buckinghamshire County Council (the Council) and the Healthcare Commission. The report contains our findings, conclusions and recommendations with regard to Mrs Keohane's areas of concern.

### The complaint

- 2 Mr Edward Hughes, Mrs Keohane's brother, was a 61 year old man with severe learning disabilities. He had lived in care for most of his adult life. Mrs Keohane told us her brother had been born in difficult circumstances during World War II and as a result he had suffered damage to his brain at birth. Mr Hughes also suffered from dementia, schizophrenia and heart problems. His verbal communication was limited to a few words and his behaviour could be challenging.
- 3 At the time of the events complained about Mr Hughes was living in accommodation provided by the Council at 309 Cressex Road in High Wycombe (the Care Home). He had been living there for many years and it was his settled place of residence.
- 4 On 5 May 2004 Mr Hughes was admitted to the Trust from the Care Home suffering from retention of urine (accumulation of urine in the bladder due to obstruction of the urethra – the tube down which urine passes from the bladder through the penis). Initially, he was catheterised (a tube was passed into his bladder through his penis to drain urine). However, he could not tolerate the catheter so doctors decided to operate on his enlarged prostate gland which was obstructing the flow of urine.
- 5 On 12 May 2004 he underwent transurethral resection of his prostate (where part of the prostate gland is removed via the penis using a telescopic surgical instrument). Post-operatively Mr Hughes developed heart and chest problems and his condition deteriorated. Doctors thought Mr Hughes had suffered a heart attack. On 16 May 2004 he was transferred to the Intensive Care Unit (the ICU). He recovered and returned to the Ward on 24 May 2004. At around 8.00pm on 26 May 2004, accompanied by a member of staff from the Care Home, he was discharged.
- 5 A member of staff from the Care Home accompanied Mr Hughes when he was admitted to hospital and staff visited him during his stay there. On occasions, they helped with his care and treatment. They also kept in contact with his family. Mrs Keohane and her brother, Mr Brian Hughes, visited Mr Hughes while he was on the Ward before he was transferred to the ICU and during his stay in the ICU.
- 6 When Mr Hughes was discharged, staff at the Care Home were concerned about him and stayed with him all night. On the following day they contacted the Surgery and asked for a home visit. That afternoon the GP called to see him. The GP examined Mr Hughes and decided no treatment was required and there was no reason to readmit him to hospital. That evening Mr Hughes ate a meal with the other residents, but at around 5.40pm (20 minutes after his meal) he got up and, while walking out of the dining area, he collapsed and vomited. An ambulance was called and Mr Hughes was taken to A&E at the Trust where he died at around 6.30pm.
- 7 A Coroner's post mortem was performed and the cause of death was recorded as: 1(a) organising pneumonia and 1(b) aspiration. Following a Coroner's inquest, held on

3 March 2005, this was changed to 1(a) acute on chronic aspiration. 'Organising pneumonia' refers to a situation where cellular processes which usually act to clear dead cells and other material formed as a result of a lung infection fail to work fully. This can lead to formation of fibrous tissue in the air sacs of the lungs. Aspiration occurs when fluids or solids do not pass normally down the gullet into the stomach, but instead they are inhaled into the respiratory passages and lungs. 'Acute on chronic aspiration' means that a person who has been aspirating over a period of time suffers an acute episode of aspiration.

- 8 Mrs Keohane is clear that she has no concerns about Mr Hughes' care and treatment before he was admitted to the ICU or during his stay in the ICU. She has told us her main concerns are about events around the time of his discharge from the Trust and his subsequent death. She says staff at the Trust *'just did not want him there because he was more difficult'*, *'they wanted rid of him'* and *'pushed him out'*. She also says some of the healthcare professionals involved in Mr Hughes' care *'thought he wasn't worth saving'*.
- 9 Mrs Keohane has given permission for Mencap to act as her representative. Mencap were not involved in the original complaint to the Trust. They began assisting Mrs Keohane after the inquest when she decided to ask the Healthcare Commission to review her complaint.

## The overarching complaint

- 10 Mrs Keohane believes her brother's death was avoidable and that he received less favourable treatment for reasons related to his learning disabilities. We have called these aspects of her complaint 'the overarching complaint'.

## Complaint against the Trust

- 11 Mrs Keohane complains about:

**Complaint (a):** the care and treatment Mr Hughes received following his transfer from the ICU at the Trust to the Ward. In particular, Mrs Keohane feels strongly that the discharge arrangements made by the Trust were inadequate and did not take account of the fact that he had learning disabilities which meant he required long-term residential care. She says Mr Hughes was discharged too early, especially given his clinical condition and his swallowing problems, and his ability to swallow was not properly assessed before he was discharged. She questions whether correct discharge procedures were followed and what information was given to staff at the Care Home about caring for Mr Hughes when he was discharged.

**Complaint (b):** the accuracy of information which was given to the family about Mr Hughes' condition. Mrs Keohane says that after his death new information came to light about his heart condition and a second fall. She questions why the family were not told about Mr Hughes' heart condition and the fall when he was alive.

**Complaint (c):** the way in which the Trust responded to her complaints about Mr Hughes' care and treatment. In particular, she questions why evidence which emerged at the inquest was not examined in detail or included in the response to her complaint and why it took the Trust so long to respond to her complaint.

## Complaint against the Surgery

12 Mrs Keohane complains about:

**Complaint (d):** the actions of a GP who visited Mr Hughes at his Care Home on the day he died. Mrs Keohane says the GP did not attend Mr Hughes quickly enough, did not examine him properly and should have readmitted him to the Trust.

**Complaint (e):** the way in which the Surgery responded to complaints about the GP's actions, including the time taken to respond to her complaint.

## Complaint against the Council

13 Mrs Keohane complains about:

**Complaint (f):** the actions of staff at the Care Home when Mr Hughes was discharged from the Trust. She questions whether they followed advice which they received from the Trust.

## Complaint against the Healthcare Commission

14 Mrs Keohane complains about:

**Complaint (g):** the way in which the Healthcare Commission handled her complaints. Mrs Keohane says the Healthcare Commission's reviews of her complaints took too long and did not provide her with the explanations she sought.

15 Mrs Keohane says she has not had answers to all her questions and she hopes the Ombudsmen's investigation will provide her with those

answers. She also hopes the outcome of her complaint will be that other people will not go through the same experience as Mr Hughes.

## The Ombudsmen's remit, jurisdiction and powers

### General remit of the Health Service Ombudsman

16 By virtue of the *Health Service Commissioners Act 1993*, the Health Service Ombudsman is empowered to investigate complaints against the NHS in England. In the exercise of her wide discretion she may investigate complaints about NHS bodies such as trusts, family health service providers such as GPs, and independent persons (individuals or bodies) providing a service on behalf of the NHS.

17 When considering complaints against an NHS body, she may look at whether a complainant has suffered injustice or hardship in consequence of a failure in a service provided by the body, a failure by the body to provide a service it was empowered to provide, or maladministration in respect of any other action by or on behalf of the body.

18 Failure or maladministration may arise from action of the body itself, a person employed by or acting on behalf of the body, or a person to whom the body has delegated any functions.

19 When considering complaints against GPs, she may look at whether a complainant has suffered injustice or hardship in consequence of action taken by the GP in connection with the services the GP has undertaken with the NHS to provide. Again, such action may have been taken by the

GP himself or herself, by someone employed by or acting on behalf of the GP or by a person to whom the GP has delegated any functions.

- 20 The Health Service Ombudsman may carry out an investigation in any manner which, to her, seems appropriate in the circumstances of the case and in particular may make such enquiries and obtain such information from such persons as she thinks fit.
- 21 If the Health Service Ombudsman finds that service failure or maladministration has resulted in an injustice, she will uphold the complaint. If the resulting injustice is unremedied, in line with her *Principles for Remedy*, she may recommend redress to remedy any injustice she has found.

### Remit over the Healthcare Commission

- 22 By operation of section 3(1E) of the *Health Service Commissioners Act 1993*, the Health Service Ombudsman is empowered to investigate complaints about injustice or hardship in consequence of maladministration by any person exercising an NHS complaints function. As the Healthcare Commission is the second stage of the NHS complaints procedure set out in the *National Health Service (Complaints) Regulations 2004*, it is within the Health Service Ombudsman's remit.

### General remit of the Local Government Ombudsman

- 23 Under the *Local Government Act 1974 Part III*, the Local Government Ombudsman has wide discretion to investigate complaints of injustice arising from maladministration by local authorities (local councils) and certain other

public bodies. He may investigate complaints about most council matters, including Social Services and the provision of social care.

- 24 If the Local Government Ombudsman finds that maladministration has resulted in an injustice, he will uphold the complaint. If the resulting injustice is unremedied he may recommend redress to remedy any injustice he has found.

### Local Government Ombudsman - premature complaints

- 25 By section 26(5)(a) of the *Local Government Act 1974*, as amended, the Local Government Ombudsman may not generally entertain a complaint unless satisfied that it has been brought to the notice of the council concerned and that the council has had a reasonable opportunity to investigate the complaint and reply to the complainant.
- 26 However, section 26(5)(b) makes it clear that if, in the particular circumstances of any case, it is not reasonable to expect the complainant to take the complaint to the council, a Local Government Ombudsman may accept the case for investigation notwithstanding that the complaint has not been dealt with by the council.
- 27 In this instance, Mrs Keohane's concerns about the Council emerged out of her complaint about NHS services. At the time when she submitted her complaint against the Council the NHS components of the complaint had already been accepted for investigation by the Health Service Ombudsman. Therefore, with the aim of providing a timely, integrated response for the complainant, the Local Government Ombudsman exercised his discretion and accepted the case for investigation under the provisions of the Act which governs his work.

## Powers to investigate a report jointly

- 28 The *Regulatory Reform (Collaboration etc between Ombudsmen) Order 2007* clarified the powers of the Health Service Ombudsman and the Local Government Ombudsman, with the consent of the complainant, to share information, carry out joint investigations and produce joint reports in respect of complaints which fell within the remit of both Ombudsmen.
- 29 In this case, the Health Service Ombudsman and the Local Government Ombudsman agreed to work together because the health and social care issues were so closely linked. A co-ordinated response consisting of a joint investigation leading to the production of a joint conclusion and proposed remedy in one report seemed the most appropriate way forward.

## The investigation

- 30 During the investigation our investigator spoke with Mrs Keohane and her representatives to ensure we had a full understanding of her complaint. Relevant documentation about the case was examined including: Mr Hughes' health records from the Trust, the Surgery and the Care Home; complaint correspondence between Mrs Keohane, Mencap and the bodies complained about; papers related to attempted resolution of the complaint at local level and by the Commission; and papers about internal investigations conducted by the Trust and the Council which included details of actions taken by them to remedy failings which they identified. The Trust and the Council provided additional information in response to specific enquiries. Enquiries were made of the Buckinghamshire Coroner who conducted the inquest into Mr Hughes' death.

- 31 We obtained specialist advice from a number of professional advisers (our Professional Advisers): Professor J Vann Jones, a professor of cardiology (our Cardiology Adviser); Mr P C Gartell, a surgical consultant (our Surgical Adviser); Dr J Skoyles, a consultant anaesthetist with experience of ICU work (our Anaesthetic Adviser); Ms L Stewart, a senior acute nurse (our Acute Nursing Adviser); Ms L L Clark, a senior learning disability nurse (our Learning Disability Adviser); Dr J Cox, an experienced GP (our GP Adviser); and Ms H Crawford, a consultant speech and language therapist (our Speech and Language Therapy Adviser). Our Professional Advisers are specialists in their field and in their role as advisers to the Ombudsmen they are completely independent of any NHS body and the Healthcare Commission. Their role is to help the Ombudsmen and their investigative staff understand the clinical aspects of the complaint.
- 32 In this report we have not referred to all the information examined in the course of our investigation, but we are satisfied that nothing significant to the complaint or our findings has been overlooked.

## Our decisions

- 33 Having considered all the available evidence related to Mrs Keohane's complaint, including her recollections and views and her comments on our draft report, and taken account of the clinical advice we have received, we have reached the following decisions.

## Complaint against the Trust

- 34 The Health Service Ombudsman finds that the Trust provided inadequate care and treatment for Mr Hughes following his transfer from the ICU to the Ward. In particular, the Ward nurses made entirely inadequate attempts to assess Mr Hughes' needs and to plan and deliver care for him following his transfer from the ICU. She also finds that the arrangements for his discharge were inadequate and that the Trust discharged him when it was not safe to do so. That was **service failure**. The Health Service Ombudsman concludes that these failures in Mr Hughes' care and treatment were for disability related reasons. She also concludes that in some areas of their care and treatment of Mr Hughes the Trust failed to live up to human rights principles of dignity and equality.
- 35 In addition, the Trust failed to inform Mr Hughes' family of significant events in his care, in particular the fall and the plan to discharge him. That, too, was **service failure**.
- 36 Furthermore, the Trust's complaint handling was poor and Mrs Keohane was not provided with reasonable responses to her concerns. That was **maladministration**.
- 37 As a result of **service failure** and **maladministration** by the Trust, Mrs Keohane has suffered an **injustice**. That injustice has not been fully remedied. The Health Service Ombudsman **upholds** the complaint against the Trust.

## Complaint against the Surgery

- 38 The Health Service Ombudsman finds that the GP provided a reasonable standard of care and treatment for Mr Hughes and that the Surgery responded appropriately to Mrs Keohane's complaints. She **does not uphold** the complaint against the Surgery.

## Complaint against the Council

- 39 The Local Government Ombudsman finds that the Care Home staff provided a reasonable standard of care and treatment and he considers the Council responded appropriately following Mr Hughes' death. He **does not uphold** the complaint against the Council.

## Complaint against the Healthcare Commission

- 40 The Health Service Ombudsman finds **maladministration** in the way the Healthcare Commission reviewed Mrs Keohane's complaint against the Trust. She **upholds** this aspect of the complaint against the Healthcare Commission. However, she found **no maladministration** in the way the Healthcare Commission reviewed Mrs Keohane's complaint against the Surgery. She **does not uphold** this aspect of the complaint against the Healthcare Commission.

## The overarching complaint

- 41 The Health Service Ombudsman has concluded that some of the service failures in Mr Hughes' care and treatment were for disability related reasons and that the Trust's acts and omissions constituted a failure to live up to human rights principles of dignity and equality.
- 42 It has not been possible to establish beyond doubt why Mr Hughes collapsed and died. We have not found any evidence which points directly to a cause for his collapse. There is no post mortem evidence which shows that he collapsed due to any of the most common causes of collapse for a person of his age. That said, it does seem possible to us that he collapsed due to a sudden change in his heart rhythm which led to the other events associated with his death.
- 43 We have not found that Mr Hughes died in consequence of any service failure or maladministration we have identified. Therefore, we do not conclude that his death was avoidable.
- 44 In this report we explain the detailed reasons for our decisions and comment on the particular areas where Mrs Keohane has expressed concern to the Ombudsmen.

## Section 2: the basis for our determination of the complaints

### Introduction

- 45 In simple terms, when determining complaints that injustice or hardship has been sustained in consequence of service failure and/or maladministration, the Ombudsmen generally begin by comparing what actually happened with what should have happened.
- 46 So, in addition to establishing the facts that are relevant to the complaint, we also need to establish a clear understanding of the standards, both of general application and which are specific to the circumstances of the case, which applied at the time the events complained about occurred, and which governed the exercise of the administrative and clinical functions of those bodies and individuals whose actions are the subject of the complaint. We call this establishing the overall standard.
- 47 The overall standard has two components: the general standard which is derived from general principles of good administration and, where applicable, of public law; and the specific standards which are derived from the legal, policy and administrative framework and the professional standards relevant to the events in question.
- 48 Having established the overall standard we then assess the facts in accordance with the standard. Specifically, we assess whether or not an act or omission on the part of the body or individual complained about constitutes a departure from the applicable standard.
- 49 If so, we then assess whether, in all the circumstances, that act or omission falls so far short of the applicable standard as to constitute service failure or maladministration.

- 50 The overall standard which we have applied to this investigation is set out below.

### The general standard

#### Principles of Good Administration

- 51 Since it was established the Parliamentary and Health Service Ombudsman's Office has developed and applied certain principles of good administration in determining complaints of service failure and maladministration. In March 2007 the Parliamentary and Health Service Ombudsman published these established principles in codified form in a document entitled *Principles of Good Administration*.
- 52 The document organises the established principles of good administration into six Principles. These Principles are:
- Getting it right
  - Being customer focused
  - Being open and accountable
  - Acting fairly and proportionately
  - Putting things right, and
  - Seeking continuous improvement.
- 53 We have taken all of these Principles into account in our consideration of Mrs Keohane's complaint and therefore set out below in greater detail what the *Principles of Good Administration* says under these headings:<sup>1</sup>

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<sup>1</sup> *Principles of Good Administration* is available at [www.ombudsman.org.uk](http://www.ombudsman.org.uk)

*'Getting it right'* means:

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

*'Being customer focused'* means:

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances.
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

*'Being open and accountable'* means:

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.

- Stating criteria for decision making and giving reasons for decisions.
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for actions.

*'Acting fairly and proportionately'* means:

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

*'Putting things right'* means:

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

‘Seeking continuous improvement’ means:

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

## Principles for Remedy

<sup>54</sup> In October 2007 the Parliamentary and Health Service Ombudsman published a document entitled *Principles for Remedy*.<sup>2</sup>

<sup>55</sup> This document sets out the Principles that we consider should guide how public bodies provide remedies for injustice or hardship resulting from their service failure or maladministration. It sets out how we think public bodies should put things right when they have gone wrong. It also confirms our own approach to recommending remedies. The *Principles for Remedy* flows from, and should be read with, the *Principles of Good Administration*. Providing fair and proportionate remedies is an integral part of good administration and good service, so the same principles apply.

<sup>56</sup> We have taken the *Principles for Remedy* into account in our consideration of Mrs Keohane’s complaint.

## The specific standards

### Disability discrimination

#### Legal framework

##### ***Disability Discrimination Act 1995***

<sup>57</sup> The sections of the *Disability Discrimination Act 1995* most relevant to the provision of services in this complaint were brought into force in 1996 and 1999 respectively. Although other parts of the *Disability Discrimination Act 1995* were brought into force in 2004 and further provisions added by the *Disability Discrimination Act 2005*, these changes either post-date or are not directly relevant to the subject matter of this complaint.

<sup>58</sup> Since December 1996 it has been unlawful for service providers to treat disabled people less favourably than other people for a reason relating to their disability, unless such treatment is justified.

<sup>59</sup> Since October 1999 it has in addition been unlawful for service providers to fail to comply with the duty to make reasonable adjustments for disabled people where the existence of a practice, policy or procedure makes it impossible or unreasonably difficult for disabled people to make use of a service provided, unless such failure is justified.

<sup>60</sup> It has also been unlawful since October 1999 for service providers to fail to comply with the duty to make reasonable adjustments so as to provide a reasonable alternative method of making the service in question available to disabled people where the existence of a physical feature makes it impossible or

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<sup>2</sup> *Principles for Remedy* is available at [www.ombudsman.org.uk](http://www.ombudsman.org.uk)

unreasonably difficult for disabled people to make use of a service provided, unless such failure is justified.

- 61 Since October 1999 it has been unlawful for service providers to fail to comply with the duty to take reasonable steps to provide auxiliary aids or services to enable or facilitate the use by disabled people of services that the service provider provides, unless that would necessitate a permanent alteration to the physical fabric of a building or unless such failure is justified.

### Policy aims

- 62 The *Disability Discrimination Act 1995* recognises that the disabling effect of physical and mental impairment will depend upon how far the physical and social environment creates obstacles to disabled people's enjoyment of the same goods, services and facilities as the rest of the public.
- 63 The key policy aim behind the legislation is to ensure that as far as reasonably possible disabled people enjoy access not just to the same services, but to the same standard of service, as other members of the public. In other words, those who provide services to the public, whether in a private or public capacity, are to do whatever they reasonably can to eradicate any disadvantage that exists for a reason related to a person's physical or mental impairment.
- 64 The critical component of disability rights policy is therefore the obligation to make 'reasonable adjustments', which shapes the 'positive accent' of the *Disability Discrimination Act 1995*. This obligation recognises that very often equality for disabled people requires not the same treatment as everyone else but different treatment. The House of Lords made

explicit what this means in a case (*Archibald v Fife Council*, [2004] UKHL 32, judgment of Baroness Hale), which although arising from the *Part 2* employment provisions of the *Disability Discrimination Act 1995*, has bearing on the *Part 3* service provisions also:

*'The 1995 Act, however, does not regard the differences between disabled people and others as irrelevant. It does not expect each to be treated in the same way. It expects reasonable adjustments to be made to cater for the special needs of disabled people. It necessarily entails an element of more favourable treatment.'*

- 65 As the Court of Appeal has also explained, specifically in respect of the *Part 3* service provisions of the *Disability Discrimination Act 1995* (*Roads v Central Trains* [2004] EWCA Civ 1451, judgment of Sedley LJ), the aim is to ensure 'access to a service as close as it is possible to get to the standard offered to the public at large'.

### Policy and administrative guidance

#### **Disability Rights Commission Codes of Practice**

- 66 Between April 2000 and October 2007 the Disability Rights Commission had responsibility for the enforcement and promotion of disability rights in Britain. In that capacity, and by virtue of the provisions of the *Disability Rights Commission Act 1999*, it had a duty to prepare statutory codes of practice on the law. These statutory codes of practice, although not legally binding, are to be taken into account by courts and tribunals in determining any issue to which their provisions are relevant.
- 67 Before the establishment of the Disability Rights Commission in April 2000, the relevant Secretary

of State, on the advice of the National Disability Council, published a statutory code of practice on the duties of service providers under Part 3 of the *Disability Discrimination Act 1995* entitled *Code of Practice: Goods, Facilities, Services and Premises* (1999), itself a revision of an earlier code of practice published in 1996.

- 68 On its establishment in 2000, the Disability Rights Commission consulted on a further revised code of practice, which came into force on 27 May 2002 as the *Disability Discrimination Code of Practice (Goods, Facilities, Services and Premises)*. The revised code of practice not only updated the previous codes but anticipated the changes to the law that were due to come into effect in 2004, in particular with respect to the duty to remove obstructive physical features.
- 69 The 2002 code made it clear that a service provider's duty to make reasonable adjustments is a duty owed to disabled people at large and that the duty is 'anticipatory':

*'Service providers should not wait until a disabled person wants to use a service which they provide before they give consideration to their duty to make reasonable adjustments. They should be thinking now about the accessibility of their services to disabled people. Service providers should be planning continually for the reasonable adjustments they need to make, whether or not they already have disabled customers. They should anticipate the requirements of disabled people and the adjustments that may have to be made for them.'*

- 70 It also drew attention to the pragmatic strain of the *Disability Discrimination Act 1995*. For example, in respect of the forthcoming 'physical features' duty, the code says:

*'The Act does not require a service provider to adopt one way of meeting its obligations rather than another. The focus of the Act is on results. Where there is a physical barrier, the service provider's aim should be to make its services accessible to disabled people. What is important is that this aim is achieved, rather than how it is achieved.'*

### **Valuing People: A New Strategy for Learning Disability for the 21st Century (2001)**

- 71 In 2001 the Department of Health published a White Paper, explicitly shaped by the relevant legislation (including the *Disability Discrimination Act 1995* and the *Human Rights Act 1998*), with a foreword written by the then Prime Minister, outlining the Government's future strategy and objectives for achieving improvements in the lives of people with learning disabilities.
- 72 The White Paper identified four key principles that it wanted to promote: legal and civil rights (including rights to education, to vote, to have a family and to express opinions); independence; choice; and inclusion (in the sense of being part of mainstream society and being integrated into the local community).
- 73 As the White Paper explained, the intention was that 'All public services will treat people with learning disabilities as individuals, with respect for their dignity'.
- 74 The fifth stated objective of the Government was to 'enable people with learning disabilities to access health services designed around individual needs, with fast and convenient care delivered to a consistently high standard, and with additional support where necessary'.

75 The Department of Health also published in 2001 two circulars aimed jointly at the health service and local authorities, focusing on the implementation of Valuing People and including detailed arrangements for the establishment of Learning Disability Partnership Boards: *HSC 2001/016* and *LAC (2001) 23*.

76 The Department of Health has published a series of reports to help the NHS meet its duties under the *Disability Discrimination Act 1995*.

***Signposts for success in commissioning and providing health services for people with learning disabilities (1998)***

77 This was published by the Department of Health and was the result of extensive consultation undertaken with people with learning disabilities, carers and professionals with the aim of informing good practice. It was targeted at the whole NHS and emphasises the need for shared values and responsibilities, respecting individual rights, good quality information and effective training and development. It also encourages the use of personal health records. The accompanying executive letter *EL (98)3* informs chief executives of the availability of the guidance.

***Doubly Disabled: Equality for disabled people in the new NHS – access to services (1999)***

78 This Department of Health report, also aimed at the whole NHS, contains a specific section on learning disability. It provides guidance for managers with specific responsibility for advising on access for disabled patients to services and employment. It also provides information for all staff on general disability issues. The accompanying circular *HSC 1999/093* emphasises the purpose of the document saying:

*‘... it will be essential for service providers to ensure that they have taken reasonable steps to ensure that services are not impossible or unreasonably difficult for disabled people to use.’*

***Once a Day: A Primary Care Handbook for people with learning disabilities (1999)***

79 This was issued jointly by the Department of Health and the Royal College of General Practitioners, and was specifically aimed at primary care services. It draws attention to the interface between primary care and general hospital services and sets out actions which healthcare providers should take to facilitate equal access to health services for people with learning disabilities. The overall purpose of the handbook was described in the accompanying circular *HSC 1999/103* which says:

*‘The purpose of this guidance, for GPs and primary care teams, is to enhance their understanding, improve their practice and promote their partnerships with other agencies and NHS services.’*

**In practice**

80 The practical effect of the legal, policy and administrative framework on disability discrimination is to require public authorities to make their services accessible to disabled people. To achieve this objective they must take all reasonable steps to ensure that the design and delivery of services do not place disabled people at a disadvantage in their enjoyment of the benefits provided by those services.

81 Failure to meet this standard will mean not only that there is maladministration or service failure, but that there is maladministration or service failure for a disability related reason. This does not require a deliberate intention to treat disabled people less favourably. It will be enough that the public authority has not taken the steps needed, without good reason.

82 To be confident that it has met the standard, a public authority will need to show that it has planned its services effectively, for example, by taking account of the views of disabled people themselves and by conducting the risk assessments needed to avoid false assumptions; that it has the ability to be flexible, for example, by making reasonable adjustments to its policies, practices and procedures, whenever necessary; and by reviewing arrangements regularly, not just when an individual disabled person presents a new challenge to service delivery.

83 It should also be noted that a failure to meet the standard might occur even when the service in question has been specially designed to meet the needs of disabled people. This might be because, for example, the service design meets the needs of some disabled people but not others, or because good design has not been translated into good practice.

84 It is not for the Ombudsmen to make findings of law. It is, however, the role of the Ombudsmen to uphold the published *Principles of Good Administration*. These include the obligation to 'get it right' by acting in accordance with the law and with regard for the rights of those concerned. Where evidence of compliance is lacking, the Ombudsmen will be mindful of that in determining the overall quality of administration and service provided in the particular case. In cases involving disabled

people, such considerations are so integral to good administration and service delivery that it is impossible to ignore them.

## Human rights

### Legal framework

#### ***Human Rights Act 1998***

85 The *Human Rights Act 1998* came into force in England in October 2000. The *Human Rights Act 1998* was intended to give further effect to the rights and freedoms already guaranteed to UK citizens by the *European Convention on Human Rights*. To that extent, the *Human Rights Act 1998* did not so much create new substantive rights for UK citizens but rather established new arrangements for the domestic enforcement of those existing substantive rights.

86 It requires public authorities (that is, bodies which exercise public functions) to act in a way that is compatible with the *European Convention on Human Rights*; it requires the courts to interpret statute and common law in accordance with the *European Convention on Human Rights* and to interpret legislation compatibly with the *European Convention on Human Rights* wherever possible; and it requires the sponsors of new legislation to make declarations when introducing a Bill in Parliament as to the compatibility of that legislation with the *European Convention on Human Rights*.

87 Of particular relevance to the delivery of healthcare to disabled people by a public authority are the following rights contained in the *European Convention on Human Rights*:

- Article 2 Right to life
- Article 3 Prohibition of torture, or inhuman or degrading treatment
- Article 14 Prohibition of discrimination.

### Policy aims

88 When the UK Government introduced the *Human Rights Act 1998*, it said its intention was to do more than require government and public authorities to comply with the *European Convention on Human Rights*. It wanted instead to create a new ‘*human rights culture*’ among public authorities and among the public at large.

89 A key component of that human rights culture is observance of the core human rights principles of Fairness, Respect, Equality, Dignity and Autonomy for all. These are the principles that lie behind the *Human Rights Act 1998*, the *European Convention on Human Rights* and human rights case law, both in the UK and in Strasbourg.

90 These principles are not new. As the Minister of State for Health Services remarked in her foreword to *Human Rights in Healthcare – A Framework for Local Action* (2007):

*‘The Human Rights Act supports the incorporation of these principles into our law, in order to embed them into all public services. These principles are as relevant now as they were over 50 years ago when UK public servants helped draft the European Convention on Human Rights.’*

91 The policy implications for the healthcare services are also apparent as one aspect of that aim of using human rights to improve service delivery. As the Minister of State also observed:

*‘Quite simply we cannot hope to improve people’s health and well-being if we are not ensuring that their human rights are respected. Human rights are not just about avoiding getting it wrong, they are an opportunity to make real improvements to people’s lives. Human rights can provide a practical way of making the common sense principles that we have as a society a reality.’*

92 At the time of the introduction of the *Human Rights Act 1998* in October 2000, the importance of human rights for disabled people was recognised. Writing in the Disability Rights Commission’s publication of September 2000 entitled *The Impact of the Human Rights Act on Disabled People*, the then Chair of the Disability Rights Commission noted that:

*‘The Human Rights Act has particular significance for disabled people ... The withdrawal or restriction of medical services, the abuse and degrading treatment of disabled people in institutional care, and prejudiced judgements about the parenting ability of disabled people are just some of the areas where the Human Rights Act may help disabled people live fully and freely, on equal terms with non-disabled people.’*

### In practice

93 The practical effect of the legal, policy and administrative framework on human rights is to create an obligation on public authorities not only to promote and protect the positive legal rights contained in the *Human Rights Act 1998* and other applicable human rights instruments but to have regard to the practical application of the human rights principles of Fairness, Respect, Equality, Dignity and Autonomy in everything they do.

- 94 Failure to meet this standard will not only mean that the individual has been denied the full enjoyment of his or her rights; it will also mean that there has been maladministration or service failure.
- 95 To be confident that it has met the requisite standard, a public authority will need to show that it has taken account of relevant human rights principles not only in its design of services but in their implementation. It will, for example, need to show that it has made decisions that are fair (including by giving those affected by decisions a chance to have their say, by avoiding blanket policies, by acting proportionately and by giving clear reasons); that it has treated everyone with respect (including by avoiding unnecessary embarrassment or humiliation, by enabling individuals to make their own choices so far as practicable, and by having due regard to the individual's enjoyment of physical and mental wellbeing); that it has made genuine efforts to achieve equality (including by avoiding unjustifiable discrimination, by taking reasonable steps to enable a person to enjoy participation in the processes that affect them, by enabling a person to express their own personal identity and by actively recognising and responding appropriately to difference); that it has preserved human dignity (including by taking reasonable steps to protect a person's life and wellbeing, by avoiding treatment that causes unnecessary mental or physical harm, and by avoiding treatment that is humiliating or undignified); and that it has promoted individual autonomy (including by taking reasonable steps to ensure that a person can live independently).
- 96 It is not for the Ombudsmen to make findings of law. It is, however, the role of the Ombudsmen to uphold the published *Principles of Good Administration*. These include the obligation to 'get it right' by acting

in accordance with the law and with regard for the rights of those concerned. Where evidence of compliance is lacking, the Ombudsmen will be mindful of that in determining the overall quality of administration and service provided in the particular case. In cases involving health and social care, such considerations are so integral to the assessment of good administration and good service delivery that it is impossible to ignore them.

## Professional standards

### The General Medical Council

- 97 The General Medical Council (the body responsible for professional regulation of doctors) publishes a booklet, *Good Medical Practice* (Good Medical Practice), which contains general guidance on how doctors should approach their work. This booklet is clear that it represents standards which the General Medical Council expects doctors to meet. It sets out the duties and responsibilities of doctors and describes the principles of good medical practice and standard of competence, care and conduct expected of doctors in all areas of work. Key sections of the booklet are set out at Annex A.
- 98 Paragraph 5 of Good Medical Practice current at the time of this complaint says:

*'The investigation or treatment you provide or arrange must be based on your clinical judgement of patients' needs and the likely effectiveness of treatment. You must not allow your views about a patient's lifestyle, culture, beliefs, race, colour, gender, sexuality, disability, age, or social or economic status, to prejudice the treatment you arrange.'*

## The Nursing and Midwifery Council

99 The Nursing and Midwifery Council (the body responsible for professional regulation of nurses) publishes a booklet, *The Nursing and Midwifery Council code of professional conduct: standards for conduct, performance and ethics* (the Code of Conduct) which contains general and specific guidance on how nurses should approach their work. The booklet represents the standards which the Nursing and Midwifery Council expects nurses to meet.

100 Paragraph 1 of the Code of Conduct current in early 2004 said:

*'You are personally accountable for your practice. This means that you are answerable for your actions and omissions, regardless of advice or directions from another professional.'*

*'You have a duty of care to your patients and clients, who are entitled to receive safe and competent care.'*

101 Paragraph 2 of the Code of Conduct said:

*'As a registered nurse, midwife or health visitor, you must respect the patient or client as an individual.'*

*'...*

*'You are personally accountable for ensuring that you promote and protect the interests and dignity of patients and clients, irrespective of gender, age, race, ability, sexuality, economic status, lifestyle, culture and religious or political beliefs.'*

102 Paragraph 4 of the Code of Conduct emphasised the importance of teamwork and communication. It said:

*'As a registered nurse, midwife or health visitor, you must co-operate with others in the team.'*

*'The team includes the patient or client, the patient's or client's family, informal carers and health and social care professionals in the National Health Service, independent and voluntary sectors.'*

*'You are expected to work co-operatively within teams and to respect the skills, expertise and contributions of your colleagues. You must treat them fairly and without discrimination.'*

*'You must communicate effectively and share your knowledge, skill and expertise with other members of the team as required for the benefit of patients and clients.'*

*'Health care records are a tool of communication within the team. You must ensure that the health care record for the patient or client is an accurate account of treatment, care planning and delivery.'*

103 In *Making a Difference: strengthening the nursing, midwifery and health visiting contribution to health and healthcare* (Making a Difference), issued in 1999, the Chief Nursing Officer identified a need to focus on the fundamentals of nursing care. This led to the development of a set of benchmarking tools known as *The Essence of Care: Patient-focused benchmarking for health care practitioners* (the Essence of Care), (Department of Health, 2001). At the time of this complaint benchmarking tools were available for eight areas including

food and nutrition and the safety of clients with mental health needs in acute mental health and general hospital settings. NHS Trusts were expected to develop and implement local policies that ensured compliance with the benchmark standards.

- 104 In January 2003 the Department of Health published comprehensive guidelines about discharging patients from hospital called *Discharge from hospital: pathway, process and practice* (Discharge from Hospital). The lengthy guidelines are in the form of a workbook and include principles for good practice as well as introducing a range of tools to assist professionals involved in the discharge process. Some key details from the document are set out at Annex B. Amongst the document's 'key messages' are:

*'Ensure individuals and their carers are actively engaged in the planning and delivery of their care.'*

'...

*'Agree, operate and performance manage a joint discharge policy that facilitates effective multidisciplinary working at ward level and between organisations.'*

*'On admission, identify those individuals who may have additional health, social and/or housing needs to be met before they can leave hospital and target them for extra support.'*

'...

*'Consider how an integrated discharge planning team can be developed to provide specialist discharge planning support to the patient and multidisciplinary team.'*

- 105 Appendices 5.6 and 5.7 of the guidelines specifically address the needs of people with learning disabilities, mental health problems or dementia. The importance of meeting the special needs of these groups of patients by effective multidisciplinary and multi-agency working is threaded through the guidance.

### Local policy at the Trust

- 106 The Trust provided us with a copy of their *Discharge Policy* which was in force in May 2004. Amongst the 'prime concerns' described in the policy are:

*'That patients' interests are given paramount consideration in the planning & conduct of discharge.'*

'...

*'That patients ... and their carers have the right to know their diagnosis & prognosis & to understand the implication of their treatment & medications.'*

*'That procedures implemented must show due regard for individual patient choice, cultural characteristics & personal dignity.'*

*'Discharge planning & management must aim to ensure effective & efficient resource use, & whilst all patients must have an equal quality of service no one should be discharged into an unsafe or inadequate environment ...'*

- 107 The policy goes on to set out the importance of liaison with home and community services to ensure that adequate facilities are ready for patients who are discharged. It recognises that some patients will require 'particular attention

when planning & delivering discharge/transfer of care' (including patients with continuing disability, psychiatric illness, confusion or loss of intellectual function) and emphasises the importance of a co-ordinated, multiprofessional approach. It concludes with the instruction:

*'Patients MUST NOT be discharged until the Doctors/Midwives concerned have made the decision that they are medically fit for discharge & the Health & Social Care professionals are satisfied that the essential elements of the care programme are in place.'*

## Complaint handling

### Council complaint handling

- 108 The *NHS and Community Care Act 1990* imposes on Social Services authorities a statutory duty to provide a complaints procedure. Statutory guidance has been issued by the Department of Health and authorities must have regard to it when managing complaints about their service. The statutory complaints process applicable to this complaint was that contained within the *Complaints Procedure Directions 1990* (these have now been superseded by the *Local Authority Social Services Complaints (England) Regulations 2006* and associated guidance, for complaints made after August 2006).
- 109 The 1990 Directions established a three-part process consisting of a first, informal, stage aimed at resolving the complaint at a local level, but which progressed to the formal second stage if the complainant remained dissatisfied. The matter was considered at the second stage by the designated complaints officer and an investigator might be appointed. If the complainant remained dissatisfied at the end

of this stage of the process, he had the right to request an independent review by a panel set up by the council to review the Stage 2 investigation. The panel did not carry out a fresh investigation, nor could it consider any aspect of the complaint that had not already been considered at an earlier stage. The panel had no power to make binding findings, but could make recommendations to the council to resolve the complaint. If the council rejected the findings it had to provide reasons for doing so.

### NHS complaint handling

- 110 Prior to 2004 complaint handling in the NHS was subject to various Directions which required NHS bodies to have written procedures for dealing with complaints within their organisation (known as local resolution) and to operate the second element of the complaints procedure (independent review). Complaints against primary care providers were dealt with at the local level under practice-based complaints procedures required under the provider's terms of service.
- 111 However, on 30 July 2004 the *NHS (Complaints) Regulations 2004* (the Regulations) came into force, and created the procedure applicable to this complaint. These Regulations made detailed provision for the handling of complaints at local level by NHS bodies and, if a complainant was dissatisfied with local resolution, for the complaint to be given further consideration by the Healthcare Commission. Complaints against primary care providers continue to be dealt with at the local level by practice-based complaints procedures, but likewise move to the Healthcare Commission for the second stage of the process.

## Complaints against NHS bodies

112 The Regulations (Regulation 3(2)) emphasise that complaint handling arrangements by NHS bodies at the local level must ensure that complaints are dealt with speedily and efficiently and that complainants are treated courteously and sympathetically and, as far as possible, involved in decisions about how their complaints are handled. The guidance issued by the Department of Health to support the Regulations emphasises that the procedures should be open, fair, flexible and conciliatory and encourage communication on all sides, with the primary objective being to resolve the complaint satisfactorily while being fair to all parties.

113 *Part II* of the Regulations (Regulations 3 to 13) sets out the statutory requirements for NHS bodies managing complaints at the local level and deals with such matters as who may make complaints, when they may be made and the matters which may be complained about. A dedicated complaints manager must be identified along with a senior person in the organisation to take responsibility for the local complaints process and for complying with the Regulations. Regulation 13 states that the response to the complaint, which must be signed by the Chief Executive where possible, must be sent to the complainant within 20 working days from when the complaint was made, unless the complainant agrees to a longer period. That response must also inform complainants of their right to refer the complaint to the Healthcare Commission.

### Complaints against GPs

114 Guidance to GPs is found in the 1996 *Practice-based Complaints Procedures. Guidance for General practices*. This is intended to be a good practice guide and sets

out a model for a practice-based complaints procedure with sample resource leaflets and suggested forms. It is not intended to be prescriptive, so the only mandatory part of the guidance is that relating to the national criteria. These criteria, found in paragraph 3.1, are:

- Practice-based procedures should be managed by the practice.
  - One person should be nominated to administer the procedure.
  - The procedure must be in writing and must be publicised (and should include details of how to complain further).
  - Complaints should normally be acknowledged within two working days and an explanation normally provided within ten working days.
- 115 The aim of the practice-based complaints procedure is to make the process more accessible, speedier and fairer to everyone and to try to resolve most complaints at practice level. Detailed procedures are expected to be workable, flexible and ‘user-friendly’ for patients and practices alike.

## Complaint handling by the Healthcare Commission

116 Complainants who are dissatisfied with the outcome of their complaint may ask the Healthcare Commission to consider the complaint, and *Part III* of the Regulations (Regulations 14 to 19) sets out the statutory requirements on the Healthcare Commission when considering complaints at this second level.

117 Regulation 16 states that the Healthcare Commission must assess the nature and substance of the complaint and decide as soon as it is reasonably practicable how it should be dealt with '*having regard to*' a number of matters including the views of the complainant and the body or person complained against and any other relevant circumstances. There is a wide range of options available to the Healthcare Commission for dealing with the complaint, apart from investigating it, including taking no further action, referring the matter back to the body complained about with recommendations as to action to resolve the complaint, and referring the matter to a health regulatory body.

118 If the Healthcare Commission does decide to investigate, it must send the proposed terms of reference to the complainant and the body or person complained about (and any other body with an interest in the complaint) for comment. Once the investigation begins, the Healthcare Commission has a wide discretion in deciding how it will conduct the investigation (Regulation 17) and this may include taking such advice as seems to it to be required, and requesting (not demanding) the production of such information and documents as it considers necessary to enable it properly to consider the complaint. The Healthcare Commission has established its own internal standards for the handling of complaints and although, for example, the Regulations do not specify the type of advice to be taken, the Healthcare Commission has acknowledged the need to seek appropriate guidance from a clinical adviser with relevant experience and expertise. Likewise, although the Regulations set no specific timescales for it to complete the investigatory process (Regulation 19 merely requires it to prepare a written report of its investigation

*'as soon as is reasonably practicable'*), the Healthcare Commission has said that it aims in the majority of cases to take no longer than six months to complete the process.

119 The report produced by the Healthcare Commission at the end of its investigation must summarise the nature and substance of the complaint, describe its investigations and summarise its conclusions, including any findings of fact, its opinion on the findings and the reasons for its opinion, and recommend what action should be taken and by whom to resolve the complaint or otherwise.

## Section 3: the investigation

### Background

<sup>120</sup> We have outlined the background to the complaint in Section 1 of this report. We say more about the key events associated with each aspect of the complaint in the relevant sections which follow.

### The Health Service Ombudsman's investigation of the complaints against the Trust

#### Complaint (a): care and treatment by staff at the Trust

<sup>121</sup> Mrs Keohane complains that the care and treatment provided for Mr Hughes by staff at the Trust from 24 to 26 May 2004 was inadequate. In particular, she says insufficient account was taken of his needs as a disabled person, his ability to swallow was not properly assessed, his discharge to the Care Home was poorly planned and he was discharged too early, especially as he had only just been transferred to the Ward from the ICU. She questions whether these events were related to his sudden death in the Care Home.

#### Key events

<sup>122</sup> I have set out above the general background to Mr Hughes' care and treatment at the Trust. My Professional Advisers have studied Mr Hughes' health records from the Trust and other documents and established what happened to him from the day he was admitted to the evening he was discharged. At Annex C I have summarised the sequence of events from his admission on 5 May 2004 to his transfer from the ICU to the Ward on 24 May 2004. I now describe key events following Mr Hughes' return to the Ward.

### Information from the Trust's records

<sup>123</sup> Trust records show that some time after 2.00pm on 24 May 2004 Mr Hughes was transferred from the ICU to the Ward. It is not clear precisely when he arrived there and I have found no information about his condition overnight. Nursing observations made during the morning of 25 May 2004 suggested that he had a high Early Warning Score (a measure of likely deterioration). A team of staff from the ICU visited Mr Hughes and around 10.30am nurses asked a junior doctor to review him because he appeared unwell and not very alert. The doctors found Mr Hughes should have been receiving oxygen, although the levels of oxygen in his blood were reasonable when he was breathing normal room air. They found he was agitated, would not keep his oxygen mask on and had pulled out his nasogastric tube (a tube passed through the nose into the stomach). His respiratory rate was very high and his heart rate was fast and irregular, although his blood pressure was within normal limits. The doctors ordered a series of tests including blood tests, an electrocardiogram (a tracing of the heart's electrical activity) and a chest X-ray. The ICU team visited Mr Hughes again around two hours later and found his heart rate was still fast and irregular. They also noted he was coughing when he tried to drink water and when the back of his mouth was cleared with a rigid plastic suction tube a thick creamy substance was obtained. The ICU team and the junior doctor recorded that they thought Mr Hughes might aspirate and that he was awaiting assessment by a speech and language therapist.

<sup>124</sup> Later on 25 May 2004 Mr Hughes was reviewed by a cardiology specialist registrar (a senior member of a consultant's team who specialised in heart conditions). This doctor studied Mr Hughes' recent medical history and reviewed

results of tests and investigations. He looked at the chest X-ray taken earlier in the day and he saw no evidence that Mr Hughes' lungs were blocked due to infection or inflammation, or that his heart was failing to pump adequately. He decided that Mr Hughes should receive various drugs to strengthen and control his heartbeat, control his blood pressure and guard against a possible heart attack. At about 5.00pm a senior doctor from a team specialising in chest care saw Mr Hughes and agreed with the cardiologist's treatment plan.

125 Mr Hughes was also seen on 25 May 2004 by a speech and language therapist who assessed his ability to swallow. She recorded that she could not carry out a full range of tests because Mr Hughes could not co-operate fully, for example, he could not seal his lips. She found Mr Hughes aspirated when given sips of water, but did not aspirate when given '*chilled purée*'. She recommended a diet of '*chilled purée*' only. Mr Hughes was also seen twice by a physiotherapist who used a rigid suction catheter to clear thick, white material which she thought might be yoghurt from the back of his throat. Later she recorded that Mr Hughes was walking around and '*coughing spontaneously*' (meaning he did not need encouragement to bring up secretions from his chest).

126 At around 2.30am on 26 May 2004 Mr Hughes fell when getting in or out of bed and sustained a small cut on the right side of his scalp. He was seen by a junior doctor who discussed the incident with a senior colleague. They decided that no treatment or specialist observations were needed. Later that morning Mr Hughes was seen by the Ward doctors, a microbiologist and the team from the ICU. The ICU team noted:

*'The nurses feel unable to provide fully for the patient as he requires constant attention, pulls out all lines [tubes such as intravenous infusions], fell out of bed last night. Don't know what to suggest as patient unable to comply with therapy.'*

127 Also on 26 May 2004 Mr Hughes was seen again by a speech and language therapist who assessed his ability to swallow, recommended a diet of '*thickened fluids (custard consistency) and puréed diet (warm and cold)*' and noted he would need follow-up speech and language therapy in the community. He was also seen by a physiotherapist who noted that the level of oxygen in his blood had improved, that he was coughing independently and did not require any treatment from her. During the evening he was discharged home accompanied by a member of staff from the Care Home.

128 There are no entries in the Trust records which note contact with the Care Home on 25 or 26 May 2004. There is an indication on a discharge tick list that a verbal handover was given by a nurse from the Ward to the person who collected Mr Hughes. However, there is no contemporaneous note of this conversation in Trust records. There is no evidence in Trust records of any written instructions provided to the Care Home by the Trust.

### Information from the Surgery's records

129 I have only seen one document which contains information from the Trust for the community team. This is a proforma discharge letter to the Surgery which was apparently brought back to the Care Home by the person who went to fetch Mr Hughes from the Trust. This was given to the Surgery by Care Home staff on 27 May 2004 when they asked a GP to visit Mr Hughes. The proforma includes very brief

details about Mr Hughes' admission (his diagnosis and the operation he underwent, but no information about aftercare) and lists the drugs which he needed to take. There is no mention of his stay in the ICU or the possibility that he may have had a heart attack. There is no information at all about his nursing care, his diet or speech and language therapy recommendations. A copy of this document was not found in the Trust records.

### Information provided by the Council and statements to the Coroner

- 130 The Council provided us with copies of records from the Care Home and a copy of the report of their investigation into events at the time of Mr Hughes' hospital admission and subsequent death. Their investigation was conducted soon after Mr Hughes died and their report was produced on 21 June 2004 so we consider it provides reasonably reliable evidence for our consideration of Mrs Keohane's complaint.
- 131 We have also seen copies of statements made by Trust and Care Home staff to the Coroner, who held his inquest on 3 March 2005. Although these statements were provided some months after Mr Hughes died they broadly confirm information in contemporaneous records and evidence given to the Council's inquiry.
- 132 From contemporaneous notes made by Care Home staff and from their statements to the Council's Investigator and the Coroner we know they were very concerned that Mr Hughes was being discharged back to their care.
- 133 Around lunchtime on 26 May 2004, the Locum Consultant Psychiatrist in Learning Disabilities for Buckinghamshire Learning Disabilities Services (the Consultant Psychiatrist) visited Mr Hughes at the Trust and discussed the planned discharge with Trust staff. There are no notes in the Trust records of his visit and it appears he made no contemporaneous notes in Care Home records. However, in his statement to the Coroner (dated 2 September 2004) and in evidence to the Council's inquiry, the Consultant Psychiatrist recalled speaking to a doctor (he understood she was a member of the urology team) and nurses about his concerns regarding the Care Home's ability to care adequately for Mr Hughes. In his statements he said the Trust doctor told him Mr Hughes did not need emergency medical or surgical care and was, therefore, fit for discharge. He recalled nurses telling him they were encountering problems with Mr Hughes' behaviour and this was affecting other patients on the Ward. The Consultant Psychiatrist said he felt he could not refuse to accept Mr Hughes back in the Care Home, despite his concerns. Therefore, he accepted his medical colleagues' opinion that Mr Hughes was fit to be discharged.
- 134 The Council's Investigator summarised the Consultant Psychiatrist's evidence on this matter as follows:
- [The Consultant Psychiatrist] (interview) made the decision to re-admit Mr Hughes to 309 Cressex Road on behalf of the Learning Disability Service. In making this decision, [the Consultant Psychiatrist] considered factors other than Mr Hughes' fitness for discharge. [The Consultant Psychiatrist] considered Mr Hughes' behaviour and its effect on the other patients in the hospital because he felt the hospital staff had "had enough". He was also concerned that Mr Hughes' situation could be interpreted as "bed blocking" and that this might have future repercussions for working relationships with the hospital. [The Consultant Psychiatrist] said that it was*

*difficult arguing with the hospital staff, although he did try to persuade them to keep Mr Hughes for an extra few days, to no avail, as he was aware that the nursing staff at 309 Cressex Road were apprehensive about re-admitting Mr Hughes so soon after ITU. [The Consultant Psychiatrist] felt he had to make a quick decision and that there were no other real options than to re-admit to 309 Cressex Road (interview and statement [the Consultant Psychiatrist]).'*

135 The information in the Consultant Psychiatrist's retrospective statements is supported by contemporaneous records from the Care Home. Care Home staff wrote that the Consultant Psychiatrist had told them Mr Hughes was to be discharged, although he felt he should be transferred to another ward for a couple of days as he was not fully recovered. They recorded that the Consultant Psychiatrist had been told that the Trust had not been prepared to keep Mr Hughes in hospital because they could not provide the one-to-one care he needed and because they thought he would be better in his own environment.

136 The Care Home records for 26 May 2004 also note that staff from the Care Home had raised their concerns with the Ward because they believed it would be difficult for them to give Mr Hughes the nursing care he needed. The Care Home's Senior Charge Nurse spoke to the Deputy Sister of the Ward to discuss Mr Hughes' discharge. He recorded her response which was that she had concerns about other patients because Mr Hughes was restless and going to other patients' beds. During this conversation the Deputy Sister gave brief instructions about preparing Mr Hughes' diet which were recorded by the Senior Charge Nurse. My Speech and Language Therapy Adviser has analysed these instructions in her advice which I set out below.

137 During the Council's investigation the Care Home Charge Nurse said a yellow sign giving speech and language therapy recommendations had been sent home with Mr Hughes. He said this was to be put up in the Care Home kitchen. One of the Trust's speech and language therapists told the Council's Investigator that this was normal practice as speech and language therapists were not always available to contribute to the discharge letter. There is no copy of the yellow sign in the Care Home records or in any of the records which I have examined.

138 After Mr Hughes arrived back at the Care Home the records show staff contacted the Trust again because they thought Mr Hughes was '*confused and chesty*' and because they had further concerns about him being discharged. There is a note in the Care Home records that in her telephone conversation with the Care Home Charge Nurse the Deputy Sister of the Ward said she would contact the Senior Manager of South Buckinghamshire Learning Disability Service the following day.

139 In her statement to the Coroner (dated 15 September 2004) the Deputy Sister of the Ward said she had first nursed Mr Hughes when he was admitted with retention of urine. She said she was on holiday for part of the time when he was in the ICU but was on duty on late shifts (starting at 2.00pm) when he returned to the Ward on 24 May 2004, and on 26 May 2004 when Mr Hughes was discharged. In her statement she said:

*'It was handed over that Ted could be discharged home and everything had been arranged and Cressex were very happy to care for him back in his own environment.'*

*'Ted was collected around 18.00 by a carer who cared for Ted and got him ready for discharge. I did stress to him to make sure Ted has a soft diet and his drinks had to be thickened (tin of thickener was supplied). As far as I know the drs [doctors] were happy to discharge Ted and the speech therapist was going to follow him up in the community.'*

### **Findings, recommendations and outcome of the Council's inquiry**

<sup>140</sup> The Council's Investigator looked in some detail at the way in which the Care Home staff responded to the news that Mr Hughes was to be discharged. He referred to the importance of multi-agency and multidisciplinary discharge planning and noted that in this case *'discharge planning was woefully inadequate and virtually non-existent'* and that *'this was an entirely unacceptable arrangement that should not have been permitted to occur'*.

<sup>141</sup> In terms of the Care Home's responsibilities for discharge planning, he concluded that a key problem was that there was no clear agreement about the nature of the service provided by the Care Home (whether it provided a hospital ward environment or a home). He remarked that the Care Home's senior nurses had different views on the skills and competencies of their staff. He also concluded that an over-reliance had been placed on the Consultant Psychiatrist's unilateral decision to accept Mr Hughes back into the Care Home. He said the Consultant Psychiatrist did not fully consider some of the key implications of the discharge, including nursing skills needed to manage Mr Hughes and budgetary arrangements to support any increased staffing levels.

<sup>142</sup> The Council's Investigator recognised that the Care Home staff were under pressure from the Trust to make a quick decision about taking Mr Hughes back. However, he said more time should have been taken to consult about arrangements for discharge and this should have resulted in a discharge meeting and discharge plan.

<sup>143</sup> The Council's Investigator recommended that a clear operational policy should be written which set out the type of service which residents could expect and the level of nursing skills and knowledge which would be needed to deliver this.

<sup>144</sup> The Council responded to the recommendations of its inquiry and an Operational Policy was drawn up which, amongst other matters, addresses the purpose of the Care Home and the level of nursing support available to residents. The Council also took a lead in developing a joint Admission and Discharge Policy with the Trust. This addresses problems identified in this case, including multi-agency and multidisciplinary working. It also includes a specific pathway to be followed when people with learning disabilities are admitted or discharged from an acute trust.

### **The advice of the Health Service Ombudsman's Professional Advisers**

<sup>145</sup> My Surgical Adviser found no fault with Mr Hughes' initial care and treatment. Usually a patient with acute retention of urine would be sent home with an indwelling urinary catheter and a future date would be fixed for surgery to the prostate. However, Mr Hughes was not able to tolerate the urinary catheter and without this he would not be able to pass urine freely. My Surgical Adviser said because of Mr Hughes' situation, staff reorganised their schedules

to expedite his surgery as his care could not be planned and managed in the usual way for patients with urinary retention. He said the operation and Mr Hughes' initial recovery were uneventful and when he deteriorated he was immediately admitted to the ICU.

<sup>146</sup> My Cardiology Adviser provided information on Mr Hughes' heart condition and gave his opinion on changes which occurred during and after Mr Hughes' hospital stay. He said Mr Hughes was in atrial fibrillation when he was admitted to the Trust on 5 May 2004. He explained that atrial fibrillation is a common disorder of the heart rate and rhythm in people of Mr Hughes' age and that it was being appropriately treated with drugs.

<sup>147</sup> My Cardiology Adviser studied the evidence about what happened to Mr Hughes when he deteriorated and was admitted to the ICU. He said the doctors had considered whether Mr Hughes had suffered a heart attack. They did a test called 'serum troponin' which can give an indication of whether someone has had a heart attack. My Cardiology Adviser said the serum troponin was '*mildly elevated at a peak of 2.4*'. He noted that the Trust doctors thought this confirmed that Mr Hughes had suffered a small heart attack, so they arranged for a cardiologist to see him and appropriate treatment was organised. He also noted that an echocardiogram (an investigation where sound waves are used to examine the structure and function of the heart) had been performed in the ICU. This showed the left ventricle (one of the heart's four chambers) was functioning normally, but the right ventricle was dilated, although the pressure in the right side of the heart was normal. He said this possibly indicated that Mr Hughes had a mild cardiomyopathy (a disorder of the heart muscle). My Cardiology Adviser also studied the post mortem report

and said it showed no evidence that Mr Hughes had suffered a recent myocardial infarction (a heart attack).

<sup>148</sup> My Cardiology Adviser said that in an otherwise healthy person a serum troponin of 2.4 would indicate the person had suffered a heart attack. However, in a person like Mr Hughes, who at the time was suffering from a severe infection and a degree of kidney failure, other factors influence the serum troponin level. In these circumstances he would expect to see a much higher serum troponin (between 40 and 100) before he would say this indicated the person had suffered a heart attack.

<sup>149</sup> Summing up his thoughts on this aspect of Mr Hughes' condition, and noting that he had the benefit of hindsight, my Cardiology Adviser said:

*'... there is no clear evidence that an acute cardiac event actually occurred during Mr Hughes' stay in hospital from 5-26 May 2004 although it is impossible to be completely certain but if a heart attack did occur it was small and not detectable at post mortem.'*

and

*'With the elevated troponin level it was reasonable to assume that a small heart attack had occurred and it was treated appropriately. As it happens treatment is more or less identical to what would have been prescribed for his possible mild cardiomyopathy and whether, as I think less likely, he had had a small heart attack, or whether, as I believe more likely, he had a pre-existing cardiomyopathy, the treatment given adequately covered both.'*

- 150 My Cardiology Adviser said that in terms of Mr Hughes' heart problems, the doctors had assessed and treated him appropriately and it was appropriate to discharge him from the point of view of his heart condition. However, he said the discharge communication was 'weak'. He noted that doctors had only provided a standard, very brief discharge proforma and said *'in a patient with a very difficult and medically complex inpatient stay it would have been better for more detailed information to have been passed on in written [form] for immediate insertion in Mr Hughes' community health records'*.
- 151 My Anaesthetic Adviser said when Mr Hughes was moved from the ICU to the Ward he appeared to be breathing normally, coughing and swallowing safely. He also said staff on the Ward quickly arranged for Mr Hughes to be reviewed by specialist teams, including respiratory and heart specialists. My Anaesthetic Adviser noted that on 25 and 26 May 2004 nurses correctly recorded an Early Warning Score of 6 and 7. He said these scores usually prompt nurses to ask doctors to review the patient, which is what happened in this case. He explained that the Early Warning Score is a score derived from various observations which prompts early intervention when a patient's score shows them to be at risk of deterioration. However, he also said that in this case the Early Warning Score could have been skewed by Mr Hughes' fast heart rate, which was normal for him, and his fast respiratory rate, which Trust staff may have attributed to his agitation. My Anaesthetic Adviser said that, whatever the explanation for the raised Early Warning Score, nurses appropriately asked doctors to see Mr Hughes when they recorded the score and Mr Hughes was reviewed appropriately by several doctors after he was transferred from the ICU.
- 152 My Acute Nursing Adviser said after Mr Hughes was moved out of the ICU there was no documentary evidence of appropriate plans to manage his care and treatment. She found no complete nursing assessment and no plans for managing key activities such as communication, nutrition, hydration, mobility or behaviour. She noted that when problems were identified, such as the low oxygen levels and potential aspiration of food and fluid, no nursing care plans were put in place detailing how those problems should be addressed. In particular, she noted that it was not clear whether or not Mr Hughes was meant to be drinking after he left the ICU and, if he was not supposed to be drinking, there was no plan about how fluids were to be given. She also said there is no evidence to show that staff had considered ways of managing Mr Hughes' needs in these circumstances. For example, it is clear that Mr Hughes was thirsty – at one point he drank mouthwash which he mistook for Ribena and went to the kitchen where he drank milk and water – but there is no evidence that staff had found out how to try and manage his behaviour or communicate with him about eating and drinking restrictions.
- 153 My Acute Nursing Adviser said:
- 'There is no clear evidence of how to support communication with Mr Hughes. It is documented that he has learning disabilities but no assessment or plan of how to support Mr Hughes with this.'*
- 'There should have been a clearly documented assessment of his behaviours, basic cares, likes and dislikes, methods of communication, interpretation of noises, his use of body language. This is a minimum requirement for planning his care.'*

*'The reviews undertaken by various members of the multidisciplinary team vary in the depth of assessment and recommendations. What is evident is that no one was taking an overall view of these opinions and planning the care for Mr Hughes.'*

*'The poor nursing documentation and assessment would make it very difficult for planning Mr Hughes' care and definitely would have contributed to the lack of continuity of care.'*

*'His learning disability seemed to be used as a reason for not undertaking a treatment or an assessment. There was no plan to manage his learning disabilities which would have facilitated treatments.'*

*'His care within the ward was fragmented with no clear guidance. This falls below the standard of care a patient should reasonably expect.'*

154 My Acute Nursing Adviser found 'very little evidence of a planned approach to discharge'. She said it was not clear whether all Mr Hughes' problems had been resolved so that he could be managed in the community.

155 In terms of a discharge plan, my Acute Nursing Adviser noted that the only evidence is a tick box single sheet which says that discharge information was given 'verbally to carer', but it does not say what this advice was. She also said that on this form there is an entry which implies information about Mr Hughes' diet was 'not applicable' and this section was clearly wrongly completed.

156 My Acute Nursing Adviser said that although there is a record of an intention to contact the Care Home to discuss arrangements for Mr Hughes' discharge there is no evidence in Trust records of any such contact. In her view there should have been a multidisciplinary meeting including staff from the Care Home to discuss discharge arrangements and management of Mr Hughes' various needs. She said it would not have been unreasonable to delay the discharge until this meeting took place.

157 My Acute Nursing Adviser said there is no evidence that Trust staff followed any local policies about discharge and no evidence that they referred to Department of Health guidelines about discharge planning. She said that had these guidelines been followed it 'would have allowed both Mr Hughes' clinical and social circumstances to be taken into account and managed so that a controlled, timely and appropriate discharge could go ahead'.

158 In summary, my Acute Nursing Adviser said after Mr Hughes was discharged from the ICU his care 'was not delivered to an acceptable standard'. She said:

*'Mr Hughes had clearly recognised learning disabilities and active steps were not taken to ensure that his care requirements were met. Instead, as incidents occurred these were managed, instead of his care being planned to prevent them happening.'*

and

*'I believe the absence of a planned assessment and management of Mr Hughes' learning disabilities definitely had an impact on the care and treatment that he received.'*

159 My Learning Disability Adviser shared the concerns expressed by the Acute Nursing Adviser. She said that given Mr Hughes' complex problems, nursing assessments and care planning were *'inadequate'*. In particular, she said that there was no assessment of Mr Hughes' challenging behaviour or communication and no plans to meet his needs in these areas. In terms of discharge planning, my Learning Disability Adviser again agreed with the views of my Acute Nursing Adviser. She said the discharge appeared to be a *'spur of the moment event'* and *'discharge planning was inadequate'*. She expressed particular concern about poor records of liaison between the Ward and the Care Home and the fact that Trust staff did not appear to take account of concerns expressed by staff from the Care Home. She noted that had Trust staff understood that people with learning disabilities sometimes become agitated and challenging as a means of communication when they are physically unwell, they may have been better able to offer Mr Hughes appropriate care and treatment. As it was, she considered Mr Hughes' learning disability and communication problems were allowed to become *'a barrier to him receiving a standard of care that any patient could reasonably expect ...'*.

160 In general, my Speech and Language Therapy Adviser echoed the concerns of my Acute Nursing Adviser and my Learning Disability Adviser, especially with regard to the lack of integrated assessment and care planning. With regard to the actions of speech and language therapists at the Trust, she said they responded to the request for a pre-discharge speech and language therapy assessment in a *'timely and appropriate manner'*. She said that in terms of assessment the format appeared *'fairly standard'* and the speech and language

therapist provided *'a functional observational report, which is standard practice'*. However, she was concerned about the lack of clear speech and language therapy records of the assessments and lack of recorded rationale for actions and decisions. She said the lack of contemporaneous speech and language therapy records, separate from the main medical record, made it difficult for her to review the speech and language therapists' actions. For example, she could not tell why the speech and language therapists had decided not to perform some specific tests which she felt could have been indicated in his case.

161 My Speech and Language Therapy Adviser commented on information which was passed to the Care Home staff about Mr Hughes' eating and drinking needs. She said:

*'There is no documentation of any recommendation or guidance having been given to the Care Home staff as to how to manage Mr Hughes' eating and drinking needs, ie the modification of his food and drink, either verbally or in written form. There are brief recommendations made in the medical notes as to "chilled purée" on 25.5.04 with no recommendations for fluid consistency trials, and for "thickened fluids (custard consistency) and puréed diet (warm and cold)" on 26.5.04. I am aware that the plan for discharge may have been sudden and the SLTs [Speech and Language Therapists] may have had little warning of the plan, but I would suggest that it would have been good practice to discuss recommendations with Care Home staff and nursing staff on the wards.'*

and

*'I appreciate that the timescales may not have allowed typed guidelines or a report to be produced. However, given Mr Hughes' vulnerability in terms of his health, and the urgency with which he required an adapted diet, ... some form of detailed handover to the Care Home should have taken place.*

*'The Care Home notes indicate that the [Trust] nursing staff provided information as to the food and drink consistency guidelines, but this information is not exactly as the SLT recommended. The Care Home record the information as told to them by the nursing staff as blended cold food and ice cold drinks from the fridge with thickener added to it whereas the final SLT recommendations were thickened fluids (custard consistency) and puréed diet (warm and cold).*

*'The nursing staff have provided incomplete information as to the recommended temperature of food and have provided no information as to the consistency of drink required. It is the responsibility of the SLT to ensure that their recommendations have been understood by the relevant key individuals.'*

162 With regard to Mr Hughes' discharge, she said:

*'... the lack of information provided in the medical notes in relation to all stages of Mr Hughes' discharge forces me to draw the conclusions that he was not thoroughly assessed for discharge, that it was not well planned, and that it was carried out in a hurried and untimely manner.'*

## The Health Service Ombudsman's findings

163 Mrs Keohane says that Mr Hughes received less favourable care at the Trust for reasons related to his learning disabilities. She has no complaints about his care and treatment until he was discharged to the Ward from the ICU on 24 May 2004. She believes that after he returned to the Ward his care and treatment were inadequate and, in particular, she believes he should not have been discharged. She feels strongly that Trust staff *'just did not want him there because he was more difficult'* and so they *'pushed [him] out'* to the Care Home.

164 I have considered evidence about the actions of Trust staff from various sources and I am satisfied that I have a reasonably clear picture of events from information in the different documents and accounts available to me. However, the poor nursing and speech and language therapy documentation has prevented my Professional Advisers from conducting a comprehensive review.

165 In assessing the actions of Trust staff I have taken account of relevant legislation and related policy, administrative guidance and professional standards as described in Section 2 and annexes to this report. In particular, I have referred to the requirements set out in Valuing People, Good Medical Practice, the Nursing and Midwifery Council's Code of Conduct, Discharge from Hospital and the *Disability Discrimination Act 1995*. I also refer to the Trust's own Discharge Policy.

166 Having studied the available evidence and taken into account the advice of my Professional Advisers, it is clear to me that between 24 and 26 May 2004 Mr Hughes did not receive a reasonable standard of care and treatment

and this led to his premature and poorly planned discharge to his Care Home. I also conclude that the failures in Mr Hughes' care and treatment were for disability related reasons.

167 First, I consider the way in which Trust staff assessed Mr Hughes' needs and planned and delivered his care and treatment.

168 I have described the actions of doctors who visited Mr Hughes after he was discharged from the ICU, including a microbiologist, a cardiologist and a respiratory doctor. He was also seen several times by Ward doctors and twice by specialists from the ICU. My Cardiology and Anaesthetic Advisers said Mr Hughes was assessed thoroughly and appropriately by those doctors who put in place an appropriate plan for medical management of his care, in particular his heart condition. They also said there was no reason why, from a purely medical point of view, Mr Hughes should have been kept in hospital. Having considered the evidence and taken account of the opinion of my Professional Advisers, I find no reason to criticise Trust doctors for their medical care and treatment of Mr Hughes from 24 to 26 May 2004.

169 I have also described how Mr Hughes was assessed on 25 and 26 May 2004 by the Trust's speech and language therapists. My Speech and Language Therapy Adviser said that the speech and language therapists responded promptly and appropriately to the requests for them to assess Mr Hughes' swallowing. I also note the Speech and Language Therapy Adviser's view that the speech and language therapy assessments appeared to be broadly in line with standard practice for their profession, although poor record keeping meant she could not tell why the speech and language therapists did not carry out further tests which might have been indicated. Having considered the evidence and

taken account of the opinion of my Professional Adviser, I find the Trust's speech and language therapists acted reasonably when assessing Mr Hughes' ability to swallow.

170 There is very little information about the Ward nurses' care and treatment of Mr Hughes following his discharge from the ICU. We know that they recorded some routine observations, such as blood pressure, respiration rate and heart rate. We also know they calculated an Early Warning Score, but we do not know precisely what they did as a result of their observations. I have seen no evidence which shows they assessed Mr Hughes' other needs such as nutrition, hydration, communication and safety. As my Acute Nursing Adviser has said, there is no evidence of a formal nursing assessment of Mr Hughes or any plan to meet his needs at this time. I have seen no evidence to show that, in caring for Mr Hughes, they recognised or took account of his needs as a person with learning disabilities.

171 What we do know is that the Ward nurses were finding Mr Hughes difficult to care for. They reported he was wandering around the Ward, approaching other patients and taking drinks from the kitchen. We also know that there was an incident when Mr Hughes fell and sustained a cut on his head, apparently because nurses were unable to manage him safely when he was getting in or out of bed. We also know from a record made by the visiting ICU team that the Ward nurses were having difficulty managing Mr Hughes because he could not comply with treatment. In addition, the Care Home records show that the Ward nurses felt they could not cope with Mr Hughes, even with some help and advice from Care Home staff. The Deputy Sister said to Care Home staff that Trust nurses were concerned for the safety of other patients and they wanted Mr Hughes to return to the Care Home.

- 172 Having considered the evidence and taken account of the opinion of my Learning Disability Adviser and my Acute Nursing Adviser, I find that the Ward nurses made entirely inadequate attempts to assess Mr Hughes' needs or plan or deliver care for him following his transfer from the ICU. Indeed, there is no record of any nursing care assessment or planning at this stage in Mr Hughes' stay at the Trust and little nursing record of his condition and progress. This clearly falls below the standard of care which any patient on the Ward should have received, let alone a patient with Mr Hughes' needs. It is clear to me that once he was transferred from the ICU, the Ward nurses had little idea how to look after Mr Hughes or make reasonable adjustments so they could manage his needs. Furthermore, aside from asking the Care Home staff to come into the Trust and actually carry out his care, they seemed to have had little idea where to seek help.
- 173 I find that in failing to provide the care and treatment Mr Hughes required, the Ward nurses failed to act in line with professional directives, in particular their Code of Conduct and the Essence of Care, or local, national or professional guidelines about caring for people with learning disabilities. The evidence I have seen strongly suggests the Trust had failed to respond to any of the guidance, such as Valuing People, Signposts for Success and Doubly Disabled, which had been in place for some years before Mr Hughes was admitted to the Trust in May 2004. These guidelines required the Trust to ensure arrangements were in place for appropriate care and treatment of people with learning disabilities. This was **service failure** which occurred for disability related reasons.
- 174 I now turn specifically to the way in which Mr Hughes' discharge was planned and carried out.
- 175 I have referred above and at Annex B to the Department of Health's guidelines, Discharge from Hospital, which were issued in January 2003. As I have said, this document provided comprehensive guidance and a toolkit for NHS bodies on all aspects of discharging patients. I also set out some of the key messages of that guidance. At Annex B I set out specific aspects of the guidance which refer to arrangements that should be made for people with learning disabilities.
- 176 I have referred above to the local discharge policy which was in place at the Trust in May 2004 and I set out some of the key points of that policy.
- 177 My medical Professional Advisers said Mr Hughes was medically fit for discharge because he no longer needed specialist medical care and because a plan to manage his main problem, his heart condition, had been put in place by Trust doctors. My Speech and Language Therapy Adviser said there is no evidence that the speech and language therapists acted unreasonably when assessing Mr Hughes' ability to swallow. Therefore, I have no reason to suggest that Mr Hughes was not fit for discharge from the perspective of his ability to swallow safely, as long as dietary restrictions were enforced. In this regard, I note that neither the Trust speech and language therapists, nor the physiotherapist suggested Mr Hughes was not fit for discharge because of a risk of aspiration. The physiotherapist reported that Mr Hughes did not need further physiotherapy and the speech and language therapist provided guidance on managing Mr Hughes' diet in the Care Home, which implied she thought he could be managed there. Neither said Mr Hughes needed further care or treatment in hospital.

- 178 I accept that Mr Hughes was medically fit for discharge, but I do not consider that it was safe to discharge him. I now set out the detailed reasons why I have reached this view.
- 179 My Acute Nursing Adviser, Learning Disability Adviser, and Speech and Language Therapy Adviser all said management of arrangements for discharging Mr Hughes was inadequate. My Cardiology Adviser's view was that communication between Trust doctors and community staff was '*weak*'. I have found no evidence whatsoever that Trust staff responsible for planning and arranging Mr Hughes' discharge referred to, or acted in accordance with, national or local guidance and/or policies about discharge which were in force at the time. In my view, the multidisciplinary team at the Trust who were responsible for Mr Hughes' care (including doctors, nurses and therapies staff) completely failed to enact even the most basic principles of good discharge as described in Discharge from Hospital or their own local policy.
- 180 I agree with Mrs Keohane and my Professional Advisers in that it seems each professional acted on their own, assessing Mr Hughes from the point of view of their own specialism, but failing to see him as a whole person with complex needs. I am especially critical of the Ward nurses who would normally play a central co-ordinating role in managing discharge arrangements. In this case, it seems to me that they found themselves unable to cope with Mr Hughes' needs and, therefore, took a simple, but wholly inappropriate route, which was to send him back to his Care Home as quickly as possible.
- 181 I do not propose to consider the Trust's failings against each and every aspect of national and local guidelines on discharge planning. However, I wish to draw particular attention to the Trust's failure to act in accordance with a key thrust of the guidelines – teamwork and close liaison with community services and carers. The national guidelines stress the importance of '*active engagement*', and '*effective communication*' between NHS trusts and primary care providers, as well as advocating the development of a joint discharge policy. The local policy stressed the need for a co-ordinated, multiprofessional approach to ensure adequate services were in place for vulnerable people who were to be discharged.
- 182 Given the clear national and local policy background, I was particularly concerned to find substantial evidence showing Trust staff ignored the views and representations of staff from the Care Home. Throughout Mr Hughes' stay at the Trust, Care Home staff demonstrated their professional concern and understanding of his needs. The Consultant Psychiatrist and the nurses visited him in hospital, advised on and assisted with his care, made a record of his progress and kept in contact with his family. However, when it came to arranging discharge, their opinions, including the Consultant Psychiatrist's personal representations to his medical colleagues, were disregarded. The Care Home staff were left with little choice but to accept Mr Hughes back into their care even though they had had no opportunity to discuss or plan for how they would meet his needs with the limited resources at their disposal. Trust staff showed no regard for the professional contribution of their community colleagues, giving them no chance to engage in the discharge planning process. Mr Hughes was unable to communicate his own views about his discharge. He could not express his needs and concerns, yet Trust staff rejected the contribution of those who knew him best and were best able to assess his needs and interpret his responses and reactions. This was completely unacceptable.

- 183 I was also concerned that staff at the Care Home did not utilise all the resources available to help them manage this situation when they clearly had concerns about their ability to adequately manage Mr Hughes' needs. I recognise they were put in a difficult position because the Consultant Psychiatrist had 'accepted' Mr Hughes back into the care of the learning disabilities service. Also, they were being pressed by the Trust to take Mr Hughes back as soon as possible, particularly because he was seen as a 'problem' for staff and patients on the Ward. It appears that they were given virtually no notice of the Trust's intention to discharge Mr Hughes. Evidence suggests that the Trust wanted to arrange discharge as quickly as possible on 26 May 2004. I also recognise that the Care Home staff knew Mr Hughes very well and cared about his welfare. This is clearly shown in the Care Home records, for example, in the personalised care plan which they devised for him only a month before he was admitted to the Trust. I understand that staff at the Care Home would have realised that Mr Hughes was distressed in the unfamiliar environment of the Ward and would have wanted to take him back to his own home where they could offer him the individualised care he required to meet his needs.
- 184 It is unfortunate that the Care Home staff did not seek help from other sources, such as the Community Learning Disability Team, or the Surgery (where Mr Hughes was well known to the GPs), or managers at the Council. Also, they could have sought more information from the Trust about Mr Hughes' medical needs on discharge to allow them to plan for his care and make any additional arrangements which might have been required. These issues were brought out clearly in the Council's inquiry. It seems the Care Home staff allowed themselves to be unreasonably pressurised by the Trust and this meant their approach to Mr Hughes' care at this time was reactive when it could have been proactive. They did not play as full a part as they could have done in multi-agency planning for discharge as described in Discharge from Hospital.
- 185 However, I note that the Council accepted the criticisms about discharge set out in the report of its inquiry and took swift action to remedy these failings. I also note that it was proactive in working with the Trust on developing the new Admission and Discharge Policy.
- 186 I have found specific evidence that the Trust had not responded effectively to national directives and guidelines about meeting the needs of people with learning disabilities. It seems that a local policy had been written in response to Discharge from Hospital, but this was ineffective in Mr Hughes' case. In terms of professional practice, Trust doctors did not comply with all the directives in Good Medical Practice. For example, they did not '*work with colleagues in the ways that best serve patients' interests*' (Duties of a Doctor) and they did not '*respect the skills and contributions of their colleagues*' or '*communicate effectively*' (section 36, see Annex A) with them. Trust nurses did not comply with their Code of Conduct, particularly paragraph 4, which emphasised the importance of teamwork and communication.
- 187 In conclusion, I find there was no effective multi-agency planning for Mr Hughes' discharge, despite the fact that this approach was clearly set out in national guidelines available at the time. In particular, no one took overall responsibility for ensuring he was safely discharged. In my view, although both medical and nursing staff from the Care Home did try to express concerns about Mr Hughes' discharge, and they were put under unreasonable pressure

from the Trust, they could have been more assertive in influencing discharge decisions and arrangements. That said, I have seen evidence that the Council subsequently took rapid and robust action to address the issues which led to this situation.

188 I find Trust staff completely disregarded representations from their community colleagues. In so doing they ignored the key principles of national and local guidance on safe discharge. I can understand that staff working on a busy surgical ward found Mr Hughes difficult to manage in an environment which was not ideal for his needs. I also do not doubt that they had genuine concern for the welfare of other patients in their charge. However, this did not absolve them from their responsibilities to ensure Mr Hughes was treated in the same way as any other patient who was medically fit for discharge, but whose needs meant they required extra time in hospital to ensure safe arrangements could be put in place in their home environment. In my view, the Trust's multidisciplinary team did not work together, or with colleagues in the community, as required by professional, national and local guidance and policy to ensure Mr Hughes was safely discharged.

189 The evidence I have seen leads me to agree with Mrs Keohane that Trust staff found Mr Hughes more difficult to care for than other patients who did not have his needs and, instead of trying to meet those needs in a professional way, they '*pushed [him] out*' to the Care Home. This was **service failure** which occurred for disability related reasons.

## Complaint (b): communication with Mr Hughes' family

190 Mrs Keohane questions the accuracy of information which was given to her family about Mr Hughes' condition. She asks why staff at the Trust did not tell the family about his heart condition and the second fall. It seems likely to me that some of Mrs Keohane's concerns about this matter arise from information which she was given during the complaints process after Mr Hughes had died. I refer to the way in which Mr Hughes' possible heart attack was labelled in complaint correspondence by the technical term 'troponin positive acute coronary syndrome'. I deal with this issue in the section of the report about complaint handling by the Trust. Here I consider only the evidence about information which was given to Mrs Keohane and her family while Mr Hughes was alive.

## Key events

191 Mr Hughes' condition deteriorated on 16 May 2004 and he was admitted to the ICU. Trust records show he was very ill. His blood pressure was low and his heart was beating quickly and irregularly. A series of investigations and tests were performed and Mr Hughes was sedated and connected to a ventilator which took over his breathing. He was given drugs and fluids to support his blood pressure and antibiotics to combat infection. The doctors thought that Mr Hughes had either aspirated and developed pneumonia or suffered a heart attack.

192 Mrs Keohane, her brother, Mr Brian Hughes, and sister-in-law visited Mr Hughes several times while he was in the ICU. Mrs Keohane arrived in England on 18 May 2004 and left to return to Ireland when Mr Hughes' condition was improving and he was due to return to the Ward.

193 The Trust's nursing records show a doctor spoke to Mr and Mrs Brian Hughes on 16 May 2004 and told them that the possible causes of Mr Hughes' deterioration were heart failure, bleeding into the stomach or a chest infection.

194 There is an entry in the medical record for 18 May 2004 which records a conversation between a doctor, Mrs Keohane and Mr Brian Hughes. The entry reads:

*'I have talked to patients' relatives (sister and brother) and explained he has a source of infection ?chest (has aspirated) ?urinary. I told them his renal function has improved and that inotropic [drugs to support the heart] requirements are ↓ [down or decreasing] and his cardiac function is good although has had M.I. [myocardial infarction – a heart attack] I said we would continue at present and that his chances of survival should be better than 50%.'*

195 This conversation is also recorded in the nursing records and the nurse wrote that Mr Hughes' family appeared to understand what was being said.

196 There is also a note of a conversation between a senior house officer (a junior doctor working in the ICU), Mrs Keohane and Mr Brian Hughes. The doctor recorded that he had discussed the likely source of Mr Hughes' infection, his current treatment and the plan to wean him off the ventilator as soon as possible. The doctor recorded that he mentioned Mr Hughes' need for inotropic drugs. As he was talking about drugs to support Mr Hughes' heart and circulation, I believe it is reasonable to assume that he spoke about Mr Hughes' heart condition.

197 Records from the Care Home show staff there were aware that Mr Hughes had possibly suffered a heart attack. For example, an entry for 17 May 2004 records that a staff nurse from the Care Home visited Mr Hughes in the ICU and discussed his condition with an ICU nurse. The record shows that the Care Home nurse contacted Mrs Keohane to tell her about Mr Hughes' condition.

### **The advice of the Health Service Ombudsman's Professional Advisers**

198 My Anaesthetic Adviser said there are no Trust records aside from those made when Mr Hughes was in the ICU which provide any information about communication with Mr Hughes' family or his carers.

199 My Acute Nursing Adviser said there was evidence of 'close liaison' with the family and Care Home staff while Mr Hughes was in the ICU, but that when he returned to the Ward there is little evidence of communication with his family. She confirmed that there is no record to show that Mr Hughes' family were informed that he had fallen on the night of 25/26 May 2004, or that he had been discharged to the Care Home.

### **The Health Service Ombudsman's findings**

200 Mrs Keohane complains that she was not told about Mr Hughes' heart condition, or that he had fallen on the night of 25/26 May 2004. She believes the way in which Trust staff communicated with her and her family about these matters was inadequate.

- 201 First, I consider whether Mrs Keohane was informed about her brother's heart condition. As I have noted above, Mr Hughes had atrial fibrillation which was being treated with drugs before he was admitted to the Trust in May 2004. I have described how, following Mr Hughes' deterioration on 16 May, Trust doctors carried out tests and investigations and decided it was likely that he had suffered a heart attack. They treated him for his heart condition with drugs. There is evidence in the Trust records that a junior doctor told Mr and Mrs Brian Hughes on 16 May that Mr Hughes may have deteriorated due to heart failure. There is also evidence that another doctor told Mrs Keohane and Mr Brian Hughes that the medical team thought Mr Hughes had suffered a heart attack. His contemporaneous entry in the medical notes is confirmed by an entry in the nursing notes. However, there is no further evidence of detailed discussion with Mr Hughes' family.
- 202 Therefore, I find that Mrs Keohane and Mr Brian Hughes were in fact told about the doctors' concerns about Mr Hughes' heart condition and their belief that he had suffered a heart attack. I also find that the doctors told Mrs Keohane and Mr Brian Hughes about some of the treatment Mr Hughes was receiving for his heart condition. I do not know whether this information was repeated or reinforced as there are limited records about subsequent communication with Mr Hughes' family. I also find that Trust nurses informed Care Home nurses about Mr Hughes' heart condition.
- 203 I consider there is sufficient evidence to show that doctors and nurses from the Trust made a reasonable attempt to inform Mr Hughes' family and his carers about changes in his heart condition. That said, I can fully understand why Mr Hughes' family may not remember the detail of individual conversations which they had with doctors and nurses at the Trust, especially as these took place when Mr Hughes was very ill and in the unfamiliar environment of the ICU.
- 204 I now turn to whether or not Mr Hughes' family were told about his fall on the night of 25/26 May 2004 and whether they should have been told about this. My Anaesthetic and Acute Nursing Advisers said there is no evidence of any communication with Mr Hughes' family after he returned to the Ward from the ICU. My Acute Nursing Adviser said there is no evidence that the family were told about his fall or that he was being discharged to the Care Home.
- 205 I consider it was unacceptable that neither doctors nor nurses communicated with Mr Hughes' family from the time when he left the ICU on 24 May 2004 to his discharge on 26 May. Given that Mr Hughes had been very ill and had just been transferred from the ICU, it was reasonable for Mrs Keohane to expect that either she or her brother would be informed of his progress and the plan to discharge him. I am persuaded that Trust staff did not keep Mr Hughes' family up to date at this important time in his stay at the Trust. Mrs Keohane and/or Mr Brian Hughes should have been told that Mr Hughes had fallen during the night, been informed of the consequences of that fall and any action which had been taken. This was **service failure** which was at least in part for disability related reasons.

## Complaint (c): complaint handling by the Trust

206 Mrs Keohane complains about the way in which the Trust handled her complaint about Mr Hughes' care and treatment. In particular, she questions why evidence which emerged at the inquest was not examined in detail or included in the Trust's response and why it took the Trust so long to respond to her complaint.

207 In Section 2 of my report I have set out the key elements of the NHS complaints process. The sections of the Regulations which apply to this aspect of the complaint are those about local resolution – Regulations 3 to 13.

### The complaint to the Trust

208 On 27 May 2004 Mrs Keohane rang the Trust to complain about Mr Hughes' care and she was advised to write to the Trust so that her concerns could be addressed. On the same day she wrote out her complaint. It appears she was writing just before her brother collapsed. She said she was happy with care in the ICU:

*'But only a few hours back in the urinary ward and things became unsatisfactory. They did not want to have to care for him, too much trouble because he was handicapped and does not speak very much.'*

209 On 13 June 2004 Mr Brian Hughes wrote to the Trust. He described events leading up to his brother's death. He said:

*'In my opinion, my brother was discharged far too early and his best interests were not served so he met his death through a lack of care and attention.'*

210 He also said insufficient attention had been paid to his brother's *'lack of communication skills along with his mental handicap and learning difficulties'*.

### The Trust's response

211 On 28 June 2004 the then Chief Executive responded to Mrs Keohane. She copied her letter to Mr Brian Hughes. In summary, the main points of her response were:

- Mr Hughes had been admitted suffering from chronic urinary retention and the normal treatment would have been to catheterise him and discharge him with the catheter in situ. However, Mr Hughes was not able to tolerate the catheter so his *'special needs were taken into consideration'* and arrangements were made for him to stay as an in-patient for an emergency transurethral resection of his prostate. She said Mr Hughes was given priority over other patients.
- Urology Department staff *'continually liaised'* with carers from Mr Hughes' home and arranged for his carers to be with him after the operation.
- Mr Hughes had deteriorated, suffered a heart attack and was admitted to the ICU. He recovered and was transferred back to the Urology Ward.
- Mr Hughes was discharged to his home and *'At no point in the discharge process did the carer raise any queries or concerns that Mr Hughes was not ready for discharge'*.

- The care Mr Hughes received was ‘of a very high standard’ and staff ‘made every effort to ensure Mr Hughes was treated with respect and they initiated special arrangements to ensure he was properly supported throughout his time in the hospital’.
- 212 The Chief Executive’s response included a summary of information provided by the Council about events at the time Mr Hughes collapsed in the Care Home.

### Further contact with the Trust

- 213 On 9 July 2004 Mrs Keohane telephoned the Trust and spoke to the Complaints Officer. She said she was unhappy with the Trust’s response. She raised issues about the decision to discharge Mr Hughes and mentioned the role of the Care Home. The Complaints Officer suggested that a meeting with Trust staff might resolve Mrs Keohane’s concerns. She also confirmed that information provided by the Care Home had been included in the investigation. However, she said Mrs Keohane would have to make a separate complaint about the Care Home if she wanted to raise further issues about Mr Hughes’ care there. This advice was correct, although the Complaints Officer could have been more helpful by putting Mrs Keohane in contact with the Council.
- 214 On 5 July 2004 Mr Brian Hughes wrote to the Trust asking if it had received his previous letter, although this letter did not arrive at the Trust until 20 July 2004. On 21 July 2004 the Trust replied outlining the action it had taken in responding to Mrs Keohane and explaining it was waiting for her further comments. A copy of the original response was enclosed.

- 215 It appears that neither Mrs Keohane nor Mr Brian Hughes contacted the Trust again or took up the Trust’s offer of a meeting. Mrs Keohane has since explained that this was because it was not practical for her to travel from Ireland for a meeting and she hoped the inquest would answer her outstanding questions. However, on 11 May 2005, around two months after the inquest, Mrs Keohane asked the Healthcare Commission to review her complaint to the Trust.

- 216 I consider the Healthcare Commission’s actions later in this report. In summary, the Healthcare Commission identified three key issues in the complaint to it: (i) the Trust’s response dated 28 June 2004; (ii) Mr Hughes’ fall on 15 May 2004; and (iii) whether Mr Hughes was discharged too early. The Healthcare Commission was highly critical of the Trust’s response of 28 June 2004 saying it ‘failed to provide a complete and accurate picture and the statements and the investigation they undertook failed to bring to light issues which came out at the inquest’. It referred all three issues back to the Trust for further action and made three recommendations. Two recommendations referred in general to the way the Trust should respond when an inquest had been held, including making further contact with the bereaved family. The third recommendation required the Trust to give a further response about events at the time of Mr Hughes’ discharge.

### The Trust’s response to the Healthcare Commission’s decision letter

- 217 On 29 March 2007 (nine months after the Healthcare Commission issued its decision letter) the current Chief Executive wrote to Mrs Keohane with the Trust’s response to

the matters referred back by the Healthcare Commission. After setting out the background to the complaint the Chief Executive addressed specific issues raised by the Healthcare Commission.

218 She acknowledged that the Trust's response letter of 28 June 2004 did not cover all the aspects discussed at the inquest and *'did not provide a complete picture of everything that had happened with regard to Ted's care and treatment and discharge back to 309 Cressex Road'*. However, she said the Trust had followed usual practice after issuing a response because they had offered to meet Mrs Keohane or Mr Brian Hughes so any outstanding issues could be addressed.

219 The Chief Executive apologised that Mr Hughes' family had not been informed that Mr Hughes had fallen on 25/26 May 2004. She also reported on a further investigation of the incident which she said showed that Mr Hughes had not *'jumped over the bed'* and fallen as originally reported, but had jumped back onto the bed and fallen having got up to go to the toilet. She said the Trust had learnt from this incident and outlined the actions which had been taken to address the issue.

220 She acknowledged the Trust had not fully addressed Mrs Keohane's concerns about Mr Hughes' discharge. She gave an explanation of events which included descriptions of the assessments carried out on 25 and 26 May 2004 by doctors, speech and language therapists and physiotherapists. When discussing the cardiology assessment she said:

*'It was felt that his troponin positive acute coronary syndrome should be treated conservatively with the decision for more invasive investigations if he developed chest pain or showed evidence of acute myocardial ischaemia (heart disease) in the future.'*

221 She also said it was decided that Mr Hughes could be discharged, so staff telephoned the Care Home to arrange discharge to an environment where *'conservative treatment could be continued in a more comfortable and familiar setting with the staff specially trained to cater for his special needs'*.

222 The Chief Executive went on to say that at the inquest staff from the Care Home, including the Consultant Psychiatrist, had raised concerns about the discharge but these concerns were not recorded in Mr Hughes' Trust records. She noted that in his court statement the Consultant Psychiatrist had said he discussed his concerns with a female registrar and had mentioned that Mr Hughes appeared to be blocking a bed. However, she said there are no records of these conversations and, therefore, she could not *'shed any further light on this'*.

223 She also said:

*'An acute hospital cannot, and does not, discharge any patient, whether this is to a family, or to a residential unit, without the surety that the patient will be accepted back home and that the patient will be either able to look after themselves or provided with the appropriate levels of support.'*

224 In terms of complaint handling, the Chief Executive said the Trust had liaised with Adult Social Care, but they had been informed that Adult Social Care would be undertaking their own investigation. However, information from a statement from Adult Social Care was used in the original Trust response. She noted that no concerns were raised by Adult Social Care about Mr Hughes' care at the Trust. However, in their response to my specific enquiries, the Council told me that they had shared the outcome of their inquiry, but not the full report, with senior staff at the Trust (including the then Director of Nursing and her deputy) at an initial meeting on 3 September 2004 and at a wider meeting on 18 November 2004. They also said a new joint Admission and Discharge Policy had been developed as a result of discussion and joint working with the Trust.

225 The Chief Executive also said Trust records did not include instructions to the Care Home regarding Mr Hughes' diet, but the records did show that the Deputy Sister had discussed this with the carer who collected Mr Hughes and she had provided a tin of thickening powder.

226 She addressed the Healthcare Commission's view that following the inquest the Trust should have considered whether anything could be added to the complaint and, if so, they should contact the complainant. She said that she believed it *'was unacceptable to actively pursue a family that have had to endure an unexpected loss'* and that such an approach could be considered *'uncaring'* and *'imposing on their grieving process'*. She said the offer of a meeting following a response to a complaint is always open to complainants.

227 The Chief Executive apologised for the delay in providing the response.

## Mencap's response

228 On 22 May 2007 Mencap wrote to the Trust setting out *'questions and concerns that remain outstanding'*. These were: the length of time taken by the total complaints process; emergence of information which was previously unknown to Mr Hughes' family (the second fall and his 'troponin positive acute coronary syndrome'); lack of action by the Trust in response to the inquest findings; and further issues about the complaints process (including the scope of the Trust's investigation regarding swallowing assessments, discharge arrangements, views of Care Home staff and the role of the GP and Mental Health Trust).

## The Trust's response to Mencap

229 On 30 July 2007 the Chief Executive responded to Mencap's letter. In summary she:

- agreed that delays in the complaints process were unacceptable. She reiterated her apologies and said as a result of the complaint the Complaints Department had undergone a number of changes;
- apologised that Mrs Keohane had lost confidence in the complaints process and offered assurances about changes;
- reiterated that action had been taken to improve incident reporting;
- reported on a review by one of the Trust's consultant cardiologists who had said that 'troponin positive acute coronary syndrome' meant the same as having a heart attack and added that Mr Hughes' health record showed the family had been informed that he had suffered a heart attack; and

- explained that the inquest and the complaints process were two separate processes and reiterated her point that it would not be appropriate for the Trust to pursue the family following the inquest.

230 In terms of the robustness of the Trust's response to the complaint, the Chief Executive said the Trust did try to include the agency with responsibility for the Care Home in its response but they declined this opportunity. She also reported on a review of the action of the speech and language therapists by the Head of Therapies who had not been involved in Mr Hughes' care. She said this review showed that appropriate action had been taken, given the difficulties of assessing Mr Hughes. In terms of Mencap's concerns about Mr Hughes' discharge she reiterated the position taken in her previous response. In particular, she said the concerns raised by the Care Home staff did not come to light during the initial investigation and there was no record of the Consultant Psychiatrist's conversations with doctors at the Trust. She also said the Consultant Psychiatrist did not approach '*the relevant acute care consultant*'.

### The review commissioned by the Trust

231 In April 2007 the Trust commissioned a review of the way in which it handled complaints related to patients with learning disabilities. The terms of reference, which were shared with Mrs Keohane and the Healthcare Commission, were: to analyse the process/thoroughness of the investigation into the complaint raised by Mrs Keohane following Mr Hughes' death; to identify whether the process of the complaints investigation on the Ward was robust enough to provide a response to the complainant; and to analyse a random selection of complaints to

assess whether there had been improvements in the complaint handling process. In the event, the review was not confined to complaint handling because, in the course of its investigation, the investigation team unearthed problems with Mr Hughes' management as a person with learning disabilities.

232 The investigation team included three senior staff from outside the Trust, including two people from the Ridgeway Partnership which by then had taken over responsibility for community mental health services in the area. The team was led by the Medical Director, Ridgeway Partnership. Other team members were the Governance Lead, Ridgeway Partnership, the Assistant Director Practice Development, Heatherwood and Wexham Park Hospitals NHS Foundation Trust and the General Manager of Medicine from the Trust.

233 The investigation team reported in July 2007. It described how it had created a process map to analyse the complaint about Mr Hughes. It identified 22 points of concern under the headings of: the complaint procedure; record keeping and documentation; involvement in the investigation process; critically reviewing patient care; and lessons learnt. It concluded that the investigation process carried out by the Ward was flawed in that it failed to identify facts which became known at a later date. It said '*staff in the urology team failed to take notes of key discussions and appeared not to have volunteered information in relation to Mr Hughes' discharge which must have been known to them at the time*'.

234 From the audit of complaints the investigation team identified key failings and concluded that '*work still needs to be done to improve the efficiency of complaint handling*'.

235 The investigation team made 12 recommendations about complaint handling in general and 7 recommendations specifically about Mrs Keohane's complaint. These are set out at Annex D.

236 On 26 July 2007 the Director of Nursing and Patient Standards wrote to Mrs Keohane enclosing a copy of the report. She offered her *'sincere apologies for the continuing distress'* which Mrs Keohane was experiencing. She did not offer specific apologies for the poor care and treatment Mr Hughes had received, but she said:

*'Both me [sic] and my board colleagues ... found this a deeply distressing account both of the handling of your complaint and also the care Ted received.'*

237 She also tried to telephone Mrs Keohane, but was unable to get through. She invited Mrs Keohane to meet her and other senior members of staff, either at the Trust or in Ireland, to discuss the report. So far, Mrs Keohane has not taken up this offer.

238 On 17 August 2007 the Trust's Governance Committee 'signed off' an action plan which had been developed to address the recommendations of the investigation. On 20 August 2007 the Director of Nursing and Patient Standards sent a copy of the plan to Mrs Keohane.

239 On 16 November 2007 the Director of Nursing and Patient Standards wrote to Mrs Keohane to inform her that the Trust had set up a multi-agency working group (including Mencap and a learning disabilities health liaison nurse) *'to review and approve training for staff to improve the care of patients with learning disabilities'*. She said the group would also take responsibility for work on the action plan.

### The advice of the Health Service Ombudsman's Professional Advisers

240 My Acute Nursing Adviser observed that the recommendations from the review and the subsequent action plan would provide a clear audit trail of actions and accountabilities and *'should ensure that issues are effectively addressed in a transparent and timely way'*. She said the recommendations and action plan would provide a *'standard against which processes and interventions will be measured'*. My Learning Disability Adviser said the recommendations for future care of patients with learning disabilities appeared *'fairly robust'*. She made some specific suggestions for extending the ideas in the recommendations around managing patients with complex problems including challenging behaviour. These suggestions included: introducing training programmes for staff; using a standard risk assessment tool; using a standard format for detailed care planning; and liaising closely with community and mental health specialists through formal advice networks.

### The Health Service Ombudsman's findings

241 Mrs Keohane remains dissatisfied with the way the Trust handled her complaint. Her main points are that the Trust took too long to respond and, even following their more detailed later responses, she feels they have not properly investigated her complaint or answered all her questions.

242 I can understand why Mrs Keohane is unhappy with the Trust's response to her complaint and why she feels the complaint process has been complex and prolonged. Although she first complained in May 2004, she did not receive detailed responses from the Trust until March and July 2007 – more than three years after

Mr Hughes died. However, despite the fact that there were serious failings in the Trust's approach to this complaint which I go on to explain, I find that an unfortunate combination of circumstances exacerbated the delay and complexity which Mrs Keohane experienced.

243 First, the fact that Mrs Keohane lives in Ireland undoubtedly made it more difficult for her to complain. As she said to my investigator, she did not know anything about the NHS complaints process. She began to write her initial letter of complaint to the Trust because she wanted to express concern about Mr Hughes' discharge, but while she was writing she received news of his death.

244 Secondly, the inquest and the actions of the Healthcare Commission influenced the progress of the complaint. One of Mrs Keohane's complaints about the Trust is that it did not include information which came to light at the inquest in its response to her complaint. This was partly because of the failings in the Trust's initial investigation but also simply because the inquest took place nine months after the Trust first responded to her complaint. Mrs Keohane has told us she did not take up the Trust's offer of a meeting to discuss her concerns about its response to her complaint partly because she lives far from the Trust and partly because she thought the inquest would provide her with the answers to her outstanding questions. Her decision was entirely reasonable. Unfortunately, it seems the inquest left her with more questions than answers. For example, new information came to light about the role and views of Care Home staff which led her to question further the Trust's decision to discharge Mr Hughes. Also, discussion of clinical information at the inquest left her with doubts about the actual reason why Mr Hughes died.

245 After the inquest Mrs Keohane could have returned to the Trust to ask for further information and explanation. I note the Trust's offer of a meeting was still open. However, Mencap suggested that Mrs Keohane asked the Healthcare Commission to review her complaint. Unfortunately, this decision may not have led to the clarity which Mrs Keohane naturally sought. Rather, because of flaws in the way the Healthcare Commission handled the review of the complaint, it led to further confusion and delay.

246 The Healthcare Commission's actions are considered in a later section of this report.

247 Having set out some of the factors which influenced the progress of Mrs Keohane's complaint to the Trust, I now consider the way in which the Trust responded to her complaint.

248 The Trust's response to Mrs Keohane's original complaint was prompt, within a month of receipt of her letter which was in line with the timeframe in the Regulations. However, there is evidence that the investigation was inadequate. The investigation was not conducted in accordance with the Regulations. In particular, there was no robust attempt to gather clinical information or question staff about their actions, there was an over-reliance on the fact that nothing was recorded in Trust records (especially interaction with Care Home staff) and the main issues, Mr Hughes' discharge and his learning disabilities, were barely addressed at all. Furthermore, the tone of the letter was defensive. The focus was on justifying the actions of Trust staff, rather than exploring and explaining those actions. This does not conform with the approach set out in Regulations 12 and 13. The poor investigation and response indicate to me that the Trust did not recognise the seriousness of the matters complained about.

- 249 It is not clear to me why it took the Trust nine months to respond to the Healthcare Commission's decision letter. I recognise that the Trust has apologised to Mrs Keohane for this delay, but I find that the Trust's inaction during this time is a further indication of its failure to recognise the seriousness of the matters complained about. The response indicates that some additional investigation had been conducted, for example there is more information about Mr Hughes' fall on 25/26 May 2004 and more detail about the assessments undertaken by staff before Mr Hughes was discharged. Unfortunately, in giving more detail about the assessment of Mr Hughes' heart condition, the Trust introduced the idea that he was suffering from 'positive troponin acute coronary syndrome' and suggested he might have developed serious complications as a result. This was apparently new clinical information (although in fact it was just a specialist medical description of his heart condition) which was included with no lay explanation. Understandably, this caused Mrs Keohane more anxiety and led her to believe that the Trust had not kept her fully informed about her brother's heart condition.
- 250 Moreover, the overall tone of the letter was still defensive. There was no recognition that the Trust may have been at fault. The Chief Executive's letter implies that because the Trust had no record that Care Home staff were concerned about Mr Hughes being discharged the Trust itself had no reason to be concerned. However, I have seen Care Home records which clearly document conversations between staff at the Trust and the Care Home in which the concerns of Care Home staff were recorded. Also, we know the Council's inquiry reported on 21 June 2004 and the summary results were shared with senior staff at the Trust on 3 September and 18 November 2004. I am not persuaded that the Trust took full account of this information when drawing up their response at this stage. That said, I agree with the Chief Executive's comments about the link between the inquest and the complaints process.
- 251 When Mencap wrote to the Chief Executive of the Trust in May 2007 with specific points about her letter of 29 March she took around two months to respond. Her letter indicated that she had sought some additional information to enable her to explain Mr Hughes' heart condition and the speech and language therapy assessments. However, she mainly focused on assuring Mencap that there had been improvements in complaint handling and incident reporting at the Trust. I particularly note that the Chief Executive did not change her position with regard to discharge arrangements for Mr Hughes. In fact, she reaffirmed her contention that there was no evidence that the Consultant Psychiatrist had expressed concerns to doctors at the Trust.
- 252 I can understand why the Chief Executive's responses to the Healthcare Commission's decision letter and Mencap's follow-up letter did little to address Mrs Keohane's concerns. In particular, the inadequate approach to investigating issues led to piecemeal, unconvincing responses. Key issues, including Mr Hughes' learning disabilities, were poorly addressed, the tone of the responses remained defensive and there was no acknowledgement that the Trust could be at fault, other than in terms of the complaints process. I am also concerned that the Trust failed to take appropriate account of the results of the Council's inquiry which were shared with it in autumn 2004. Rather, it continued to say that the Council was not co-operating with its investigation.

253 I am especially concerned by the lack of co-ordinated attention to the complaint after the Chief Executive's response of March 2007. In April 2007 the Trust instigated a review of events associated with Mrs Keohane's complaint. Mrs Keohane was informed about the review and on 26 July 2007 the Director of Nursing and Patient Standards wrote to her with a copy of the report of the review which was highly critical of the Trust's management of Mrs Keohane's complaint. The report also made seven recommendations, set out at Annex D of this report, about caring for people with learning disabilities. In my view these actions were appropriate. However, on 30 July 2007 the Chief Executive wrote to Mencap without any mention of the review or its outcome and without any acknowledgement or apology for the failures in care and treatment provided for Mr Hughes which the Trust's own review had revealed.

254 I find that there were significant failings in the way in which the Trust managed Mrs Keohane's complaint. In summary, the Trust:

- failed to recognise or address the most serious issues complained about;
- failed to conduct an appropriate investigation;
- adopted a defensive approach;
- failed to provide appropriate co-ordinated responses;
- at times, took too long to respond to correspondence; and
- failed to acknowledge and apologise for poor care and treatment.

255 These failings amount to **maladministration**. Furthermore, in key areas of their management of this complaint the Trust did not act in accordance with the Regulations or with the principles of good administration.

### Complaints against the Trust: the Health Service Ombudsman's conclusion

256 I am in no doubt that after Mr Hughes was transferred from the ICU to the Ward, the Trust failed to recognise, take account of, or meet his needs as a person with learning disabilities. I agree with Mrs Keohane that Mr Hughes was discharged inappropriately to his Care Home because Trust staff found him difficult to manage. Furthermore, Trust staff failed to work as a team with colleagues in the community to secure his safe discharge. I found that Trust staff did tell Mr Hughes' family about his heart condition, but after his transfer from the ICU they failed to inform his family about significant events in his care, especially the fall on the night of 25/26 May 2004 and the fact that he was to be discharged. I conclude that there were **service failures** in the care and treatment the Trust provided for Mr Hughes after he was transferred from the ICU to the Ward.

257 The way in which the Trust managed Mrs Keohane's complaint was seriously flawed. This was **maladministration**.

### Injustice

258 The Trust informed me of action which it took to address the shortcomings identified during its review of Mr Hughes' case and Mrs Keohane's complaint. I have set out this information above. My Professional Advisers have told me that this action would go some way towards addressing the failings identified, although my

Learning Disability Adviser thought the Trust could have taken more robust action in terms of care of people with learning disabilities. Some of her suggestions are covered in the Trust's subsequent actions.

259 In her response to my draft report the Chief Executive acknowledged the key failings I identified in my investigation and gave further details of recent action at the Trust aimed at addressing those failings. She said:

*'I am mindful that this has been an extremely lengthy and distressing time for Mrs Keohane and other family members. The period since these very sad events is considerable and has spanned three different chief executives and management teams in this Trust. I wish once again, to personally reiterate on behalf of the Trust my sincere apologies to Mrs Keohane and the family that Mr Hughes did not receive the expected standard of care and discharge planning between the dates of 24th – 26th May 2004.'*

260 The Chief Executive summarised the key actions taken by the Trust as follows:

- *'A Learning Disability Health Conference was held at the Trust in 2005.*
- *We commissioned an inquiry into the complaint handling of this case to help learn and inform the improvement made to our complaints handling processes.*
- *We have reviewed and updated relevant key policies such as the Discharge Policy and the Vulnerable Adults Policy and used the learning from these sad events to inform policy development.*

- *We are working in partnership with other agencies through a variety of groups and named links.*
- *A training programme open to all staff and volunteers has been put into place. Training will be delivered mainly by those who have learning disabilities.*
- *Each ward has a designated discharge co-ordinator and fortnightly meetings are held with key staff from across the health economy to ensure that any concerns regarding services or discharge arrangement can be raised and followed up on.*
- *Essence of Care has been re-launched.*
- *Matrons undertake formal rounds.*
- *Training in good record keeping is ongoing and regular audits are undertaken.*
- *Documentation on acute wards had now changed into a multidisciplinary care note.'*

261 The Chief Executive said:

*'In our attempt to outline the actions that we have undertaken, we hope to demonstrate the lessons that we have learnt and the seriousness with which we have taken these events. It is also our aim that these actions will minimise the risk of reoccurrence.'*

262 She also offered to meet Mr Hughes' family to discuss his care and the changes that have been made at the Trust.

263 Having considered the evidence put forward by the Trust about changes which have occurred since Mr Hughes was a patient there, I find that the Trust has now taken reasonable action to address the shortcomings identified by its own inquiry. I also find that its actions will address the failings identified in this report with regard to the care and treatment provided to Mr Hughes and to complaint handling.

264 That said, I consider Mrs Keohane still has reason to be aggrieved by the failings in the Trust's care and treatment of her brother, and in particular those failings which I have concluded occurred for disability related reasons. Furthermore, she should not have had to wait for an investigation by me to establish the facts about Mr Hughes' care and treatment. Partly due to failings at the Trust, Mrs Keohane has had to wait four years for answers to her questions – four years during which she wondered whether her brother's death was avoidable. That four year wait and that uncertainty is an injustice that has not been remedied.

265 I have found **service failure** in the care and treatment provided for Mr Hughes by the Trust and **maladministration** in the way the Trust handled Mrs Keohane's complaint. This has resulted in **injustice** for Mrs Keohane.

266 Therefore, I **uphold** Mrs Keohane's complaint against the Trust.

267 I make recommendations below to remedy the injustice to Mrs Keohane which I have described in paragraph 264 above. We say more about injustice in Section 4 of this report.

### The Health Service Ombudsman's recommendations

268 I **recommend** that the Chief Executive of the Trust apologise to Mrs Keohane for the failings I have set out in this report.

269 I also **recommend** that the Trust offer compensation of £10,000 to Mrs Keohane in recognition of the injustice she has suffered in consequence of the service failure and maladministration I have identified.

### The Trust's response

270 As I have said above, the Chief Executive of the Trust has acknowledged the failings identified in this report. She has also reiterated her sincere apologies to Mrs Keohane and offered to meet her and her family to discuss Mr Hughes' care and recent changes at the Trust. I have already commented that I find these actions are appropriate and I am reassured that lessons have been learnt from this case. The Chief Executive accepted my recommendation regarding a compensation payment.

### The Health Service Ombudsman's investigation of the complaints against the Surgery

#### Complaint (d): care and treatment by the GP

271 Mrs Keohane believes that the GP did not respond quickly enough to the request from Care Home staff to visit Mr Hughes on 27 May 2004. Mencap have suggested that the GP did not arrive until 4.30pm, '*just over an hour*' before Mr Hughes died, when the request for a visit had been made in the morning. In their complaint to the Health Service Ombudsman Mencap said:

*'Ted's GP prescribed further thickening powder, but then watched Ted sit down to a normal communal meal in the care home before he left.'*

- 272 Mrs Keohane also says the GP did not examine Mr Hughes properly and that he was wrong not to readmit him to hospital.

### Key events

- 273 Mr Hughes returned to the Care Home at around 8.00pm on 26 May 2004. Records from the Care Home show staff there were concerned about him as soon as he arrived. The Senior Charge Nurse wrote that Mr Hughes appeared *'confused and chesty even though staff at the hospital say his chest is clear'*.

- 274 The Team Leader on the night shift recorded that Mr Hughes was taken to bed around 10.00pm. He wrote that Mr Hughes was *'very unsteady'* and had to be showered using a shower chair which was used to wheel him back to his bed. The Team Leader also wrote that Mr Hughes was unable to settle and staff stayed with him all night. They were concerned he would injure himself because he was restless and unsteady. He wrote that Mr Hughes settled at about 3.00am but that he had a *'very chesty cough throughout the night and looks very pale'*.

- 275 During the morning of 27 May 2004 staff at the Care Home recorded that Mr Hughes was *'looking frail, staggering – but walking quite fast and opening his eyes quite wide. Ted is really a changed person'*. Their concern led them to contact the Surgery and ask for a visit from one of the GPs. This request is not recorded in the Care Home notes. However, records from the Surgery show that a compliments slip attached to the Trust's discharge summary was delivered to the Surgery some time on 27 May 2004. The

Senior Charge Nurse from the Care Home had written an untimed and undated note on the compliments slip. The note was addressed to Mr Hughes' usual GP and said:

*'Edward Hughes has been discharged back to 309 and he is still not well, sounds chesty, unsteady on his feet, needs 1-1 constantly. Need thickener for his drinks so can we have it on Rx [prescription] please.'*

*'Thanks Sen Charge Nurse.  
Please can you come today to see Ted as he is not well still.'*

- 276 A different GP responded to the request for a visit to Mr Hughes because his usual GP was not available. The Care Home records say that the GP arrived *'around 15.00'*, examined Mr Hughes and said that he did not think Mr Hughes was chesty. The records also note that the GP asked for a specimen of urine to be collected for analysis.
- 277 The Surgery computer log shows that on 27 May 2004 the GP undertook home visits between finishing morning surgery at 12.11pm and starting afternoon surgery at 3.55pm. The computer record of the GP's visit notes that the Care Home staff were concerned by Mr Hughes' weak state and angered by the way he was discharged. It also notes that the GP considered whether Mr Hughes had a chest infection or a urinary tract infection. It also says that having examined Mr Hughes, the GP found his chest was clear and asked for a urine specimen to be taken. The record goes on to say that the GP contacted the Speech and Language Therapist at the Trust and confirmed the instructions for managing Mr Hughes' diet before prescribing drinks thickener and other medication.

## The GP's statement to the Coroner

278 On 27 February 2005 the GP provided a statement for the Coroner. In this statement he noted that the request to visit Mr Hughes had been addressed to one of his colleagues, the lead doctor for the Care Home, but he was not available. The GP said he had met Mr Hughes 'several times before' and was aware of his social and medical history. He said:

*'When I arrived to see Mr Hughes I initially discussed his problems with his carers who felt that he was much weaker than on admission to hospital ... On seeing and examining Mr Hughes I was led to the patient where he was sitting out of his room, on a chair. He wasn't notably short of breath at rest, and neither was he cyanosed [bluish coloured from lack of oxygen]. When I listened to his chest I felt there were no signs to suggest an acute chest infection. Indeed he was already on 3 medications to protect his chest from further aspiration. I wondered if his weakness was due to his rough peri-operative period [the time before, during and after surgery], but also whether in view of his recent prostate surgery he may have a urinary tract infection. When I saw him I did not feel his condition warranted readmission to hospital, but was planning to discuss the issue with the home manager the next day (he was off duty on the day I visited). I also spent quite a while tracking down his speech therapist to ensure I prescribed the correct food thickener and quantities.'*

## The Practice Manager's explanation

279 On 3 August 2006 the Practice Manager wrote to Mrs Keohane in response to her complaint about the GP's actions. She said she had discussed events with the GP who had:

*'... observed Mr Hughes walk unaided, and noted he was not short of breath. Examination of the chest was clear. [The GP] considered a urinary tract infection, and requested a specimen of urine be sent to the laboratory for testing.'*

280 The Practice Manager also said the GP did not admit Mr Hughes to hospital because:

*'... his chest was clear, with no apparent infection, and although he appeared weak as you would expect from someone recovering from surgery and pneumonia, there was no sign of recent deterioration.'*

## The advice of the Health Service Ombudsman's Professional Adviser

281 My GP Adviser said there was no suggestion on the note which requested a home visit that the visit was more urgent than 'today', so it was reasonable for the GP to visit between his morning and afternoon surgery.

282 My GP Adviser said the GP's contemporaneous note of his visit shows that he obtained a history from Mr Hughes' carers and that he examined him. He also said the note goes on to acknowledge that Mr Hughes was at risk of aspiration. My GP Adviser said the Surgery's response to Mrs Keohane's complaint confirms that the GP saw Mr Hughes walk unaided, saw that he was not short of breath, examined his chest and asked for a urine specimen to be taken.

283 My GP Adviser said:

*'Although there is a lack of detail in the clinical record about both the history taken and the physical examination findings, there is no evidence that [the GP's] assessment of Mr Hughes was either inadequate or inaccurate.*

*'[The GP's] diagnostic conclusion, that Mr Hughes was at risk of aspiration and that he might have a urine infection, were logical. By considering measures to reduce the risk of aspiration of food, prescribing a food thickener and [liaising with] a speech therapist, [the GP] went further than many GPs would have done in the circumstances.*

*'[The GP] also, correctly, continued Mr Hughes' treatment for atrial fibrillation (frusemide, metoprolol, perindopril) and infection (amoxicillin).*

*'[The GP] arranged for a speech therapist to assess Mr Hughes, requested that a urine sample be sent to the laboratory and arranged to discuss Mr Hughes' discharge from hospital with the Care Home Manager. These actions were appropriate and demonstrated a concern for both Mr Hughes and his carers.*

*'Mr Hughes had apparently been aspirating food chronically, ie over a period of time. His general weakness on discharge from hospital would almost certainly have made him more susceptible to aspiration. However, [the GP] could not have predicted that he would aspirate so severely later that day or that the consequences would be so serious.'*

284 My investigator specifically asked my GP Adviser if the GP took sufficient account of Mr Hughes' learning disabilities and whether his actions were in line with relevant professional and national guidelines. My GP adviser said:

*'[The GP] visited Mr Hughes in his home. There is no suggestion of any attempt to get Mr Hughes to travel to the surgery. [The GP] liaised with other professional people involved in his care, particularly Care Home staff and the speech therapist. [The GP] did not undertake any procedure or make any decision that would normally require explicit consent. The evidence is that [the GP] acted in Mr Hughes' best interests. There is no evidence that he discriminated against Mr Hughes because he suffered from learning difficulties, dementia or schizophrenia.'*

285 Referring to the proposals in Valuing People my GP Adviser said:

*'There is no evidence that Mr Hughes had any difficulty gaining access to GP care and there is evidence of integrated working between health professionals.'*

and

*'There is no evidence that [the GP] failed to comply with [GMC guidance] or that he discriminated against Mr Hughes in any way.'*

286 My GP Adviser concluded that:

*'I have no criticism of [the GP's] care of Mr Hughes on 27 May 2004. ... [The GP's] care and treatment of Mr Hughes was well above the minimum standard expected of a reasonable GP in similar circumstances.'*

## The Health Service Ombudsman's findings

- 287 Mrs Keohane believes that the GP's care and treatment of Mr Hughes on 27 May 2004 was inadequate. She believes that if the GP had acted differently, in particular taking more account of Mr Hughes' learning disabilities and recent discharge from hospital, he might not have died.
- 288 I can understand why Mrs Keohane finds it difficult to accept that Mr Hughes died only hours after he was seen by the GP and why, therefore, she feels the GP could have taken action to prevent his death. Unfortunately, it appears that, with the passage of time, some of the facts about the GP's visit, in particular the time he arrived at and left the Care Home, have become distorted. It seems to me that this may have understandably led Mrs Keohane to draw some conclusions about the GP's actions which are not supported by contemporaneous evidence.
- 289 I have considered evidence about the GP's actions from various sources and I have not found any significant inconsistencies in the different documents and accounts available to me. In assessing the GP's actions I have taken account of relevant legislation and standards. In particular, I have referred to the requirements set out in Valuing People and Good Medical Practice.
- 290 I have considered the advice of my GP Adviser who has made a detailed study of the contemporaneous evidence about the GP's visit. I find that there was no apparent urgency in the request for a GP to visit Mr Hughes and, therefore, it was reasonable for the GP to call on Mr Hughes in the afternoon during the time in his working day which was allocated to home visits. I also find that there is strong contemporaneous evidence to show that the GP called on Mr Hughes in the early afternoon (not just before Mr Hughes died as Mrs Keohane suggests, or at 4.30pm as Mencap have stated) because he was back in the Surgery seeing his first patient at 3.55pm. Also, the GP's time is then accounted for until his last patient left his consulting room at 6.13pm. This is corroborated by the Care Home notes which say the GP arrived there 'around 15.00'. In their document setting out the complaint to us, Mencap have said the GP was present when Mr Hughes ate his evening meal, but clearly this is not the case.
- 291 I also find that, although the record of the GP's actions is not particularly detailed, there is sufficient contemporaneous evidence to show the GP did examine Mr Hughes, including an examination of his chest, and did listen to what the Care Home staff said about Mr Hughes' condition and behaviour. I note my GP Adviser said the GP took appropriate steps to assess Mr Hughes' condition and that in so doing he took appropriate account of his needs. In particular, he liaised appropriately with his carers, recognising that they could provide him with their knowledgeable observations which would help him assess Mr Hughes' condition.
- 292 I have also considered my GP Adviser's view that, given the information which the GP had obtained from his own examination and observations, the observations of the Care Home staff and his knowledge of Mr Hughes' recent hospital stay, his diagnostic conclusions and subsequent actions were reasonable. In particular, I note my GP Adviser's opinion that *'there is no evidence to suggest that Care Home staff could not cope with his care or that Mr Hughes should be readmitted to hospital'*.

293 Furthermore, I have seen evidence which shows that the GP took particular care because he was alert to Mr Hughes' needs. He was aware that Mr Hughes was at risk of aspiration and personally took time to contact the Trust's speech and language therapy department to find out precisely what should be done to minimise the risk of Mr Hughes aspirating food. He then acted on the advice he obtained by appropriately prescribing thickener for Mr Hughes' drinks and took care to check that a follow-up speech and language therapy appointment had been made.

294 I particularly note that the GP showed concern not only for Mr Hughes, but also for the Care Home staff. They told him about their anxieties about caring for Mr Hughes and he agreed to speak with their Manager about this. I consider that, in recognising the importance of listening to and supporting the Care Home staff, the GP demonstrated an appropriate multidisciplinary approach to Mr Hughes' care. Furthermore, in agreeing to talk to the Care Home Manager he showed that he was concerned not only with Mr Hughes' immediate condition, but also with his future welfare.

295 Having considered all the evidence and taken account of the advice provided by my GP Adviser, I find there is no evidence to suggest the GP treated Mr Hughes less favourably for disability related reasons. Rather, I find he acted in accordance with professional and national guidelines on caring for patients with a learning disability. Moreover, in my view, the GP's actions demonstrated his awareness and commitment to working with patients with learning disabilities at the Care Home.

296 I conclude that there is **no evidence of service failure** in respect of the GP's care and treatment of Mr Hughes.

297 In their response to my draft report Mencap accepted they had made an incorrect assumption about the time of the GP's visit. They acknowledged that this assumption was based on their interpretation of one of the statements presented to the Coroner. Mencap asked me to note there had been no intention to mislead regarding this issue.

### Complaint (e): complaint handling by the Surgery

298 In her complaint to the Health Service Ombudsman Mrs Keohane did not specifically complain about complaint handling by the Surgery. However, she did complain about the length and complexity of the complaints process and the fact that the process had not provided her with all the answers she sought. Therefore, I have considered the way in which the Surgery handled Mrs Keohane's complaint. This allows us to present a full picture of how her complaint was managed as a whole, as well as by the different bodies complained about.

299 Mrs Keohane did not complain to the Surgery until 15 June 2006. She explained that she had not complained previously because she thought the Healthcare Commission would investigate the GP's care of Mr Hughes as well as investigating her complaint against the Trust.

300 Mrs Keohane said that she recognised that time had passed since her brother's death and that the GP would have to rely on his written records. She asked about the circumstances leading to Mr Hughes' death and questioned why the GP did not admit Mr Hughes to hospital when he saw him on 27 May 2004.

301 I have set out the key elements of the NHS complaints process in Section 2 of this report. The sections of the Regulations which apply to this aspect of the complaint are those about local resolution – Regulations 3 to 13.

### The Surgery's response

302 Two years had passed since Mr Hughes' death before Mrs Keohane complained to the Surgery. This meant that, according to Regulation 10, the Surgery could have refused to respond to her complaint because it was 'out of time'. In fact, the Practice Manager responded promptly to Mrs Keohane's letter. The Practice Manager's letter of 20 June 2006 opened with an expression of sadness about Mr Hughes' death and an offer of condolences. She went on to explain that it would take time to retrieve Mr Hughes' records and she enclosed a copy of the Surgery's complaints leaflet.

303 The tone of the second letter of 3 August 2006 was also sympathetic. The Practice Manager apologised for the delay in responding and said she had discussed Mrs Keohane's concerns with the GP and consulted the Surgery's records. I have outlined her explanation about the GP's actions and decision above. The Practice Manager was not defensive in her approach and she provided detailed, clear explanations. Furthermore, she invited Mrs Keohane to contact either herself or the GP if there were further issues she wanted to discuss.

304 On 25 August 2006 the Practice Manager wrote a follow-up letter to Mrs Keohane inviting her to contact her or the GP if she had any further queries.

305 It appears that Mrs Keohane did not contact the Surgery again because she was in correspondence with the Healthcare Commission about the GP's actions.

306 During the independent review of Mrs Keohane's complaint about the GP's care of Mr Hughes the Healthcare Commission contacted the Surgery to ask for information and the Practice Manager co-operated with its request. Subsequently, the Healthcare Commission informed the Practice Manager that Mrs Keohane had asked it to look into a second matter, namely the time of day when the GP saw Mr Hughes. The Practice Manager again answered promptly providing detailed information to assist the Healthcare Commission in dealing with the complaint. Correspondence which I have seen between the Practice Manager and the Healthcare Commission clearly shows that the Practice Manager was concerned for Mrs Keohane's welfare because of the protracted complaints process.

### The Health Service Ombudsman's findings

307 Mrs Keohane is dissatisfied with the way in which the Surgery handled her complaint about the GP's actions.

308 The Surgery could have declined to respond to both complaints because they were 'out of time' according to the Regulations. Instead, taking into account the need to retrieve records from storage, the Practice Manager responded promptly and in detail. She responded to all aspects of the complaint. She also co-operated fully with the Healthcare Commission. Her approach was understanding, sympathetic and in line with the requirements of the Regulations. In particular, I note that, despite the time which had elapsed since the events complained about, the Practice Manager offered Mrs Keohane the opportunity to make further contact with her

or the GP. In my view, this clearly indicated a genuine willingness to help Mrs Keohane resolve her concerns.

- 309 I find Mrs Keohane's complaints were handled appropriately and reasonably. I conclude there is **no evidence of maladministration** in complaint handling by the Surgery.

### Complaints against the Surgery: the Health Service Ombudsman's conclusion

- 310 I conclude that, in all the circumstances, the service provided to Mr Hughes by the GP on 27 May 2004 was of a reasonable standard. I find no reason to criticise the GP's actions, decisions or attitudes regarding his care and treatment of Mr Hughes. I also conclude that the Surgery handled Mrs Keohane's complaint promptly, appropriately and reasonably.
- 311 I conclude that there is **no evidence of service failure or maladministration** by the Surgery. Therefore, I **do not uphold** Mrs Keohane's complaints against the Surgery.

### The Local Government Ombudsman's investigation of the complaint against the Council

#### Complaint (f): care by staff at the Care Home

##### Mrs Keohane's complaint

- 312 Mrs Keohane mentioned the actions of Care Home staff when she contacted the Trust on 9 July 2005 to discuss their response to her original complaint. Subsequently, Mencap mentioned the actions of Care Home staff in a telephone conversation with the Healthcare Commission in November 2006. On both

occasions correct advice was given – that the issues of concern should be raised with the Care Home in the first instance. In the event, neither Mrs Keohane, nor Mencap complained directly to the Care Home or the Council. Mrs Keohane did not formally complain about the actions of staff at the Care Home until she contacted the Local Government Ombudsman on 5 October 2007. The Local Government Ombudsman exercised his discretion to accept the complaint for investigation even though it had not been through preliminary stages of the complaints process.

- 313 Mrs Keohane is concerned about the actions of Care Home staff after Mr Hughes was discharged from the Trust at around 8.00pm on 26 May 2004. In particular, she wants to know more about the nature of his meals. She knows that special arrangements should have been made at the Care Home to reduce the risk of aspiration, yet the Coroner decided that acute aspiration was partly the reason for Mr Hughes' death. Therefore, she is concerned that special dietary arrangements were not made and as a result Mr Hughes aspirated his evening meal and died. In the complaint to the Health Service Ombudsman, Mencap say that on the evening he died Mr Hughes sat down to '*a normal communal meal*'. In Death by *indifference* Mencap said:

*'Ted sat down and ate a communal meal. He began to vomit and then collapsed.'*

- 314 Mrs Keohane wants to know whether appropriate arrangements were made for Mr Hughes' dietary needs and, if not, was this because inadequate information was given by the Trust to the Care Home or because the Care Home staff did not follow instructions they were given. She also wants to know more about the actions of Care Home staff when Mr Hughes collapsed.

## Responsibility for management of the Care Home

315 The Council has explained that the Care Home is an NHS service (a 'small health home') providing in-patient and other services to people with learning disabilities and related needs. The service was operated by different NHS services until 2002 when the Council assumed responsibility for management of the service under the terms of a section 31 (*Health Act 1999*) agreement. This agreement utilised one of the *Health Act 1999* flexibilities to enable the local authority to manage the service on behalf of the NHS. The section 31 agreement provided for management of the staff and service by the Council. The home was close to capacity of 12 residents at the time of Mr Hughes' death. Short-stay accommodation had been phased out and Mr Hughes was one of the remaining long-stay residents. Buckinghamshire Mental Health NHS Trust (the Mental Health Trust) owned the premises and employed the staff who were seconded to the Council under the section 31 agreement. The agreement provided for management staff to be employed by either organisation, but in this case line managers and the most senior managers were Council employees and all staff accounted to the Council for their actions, whether employed by the NHS or the Council. The exception was doctors, who remained in the employment and management of the Mental Health Trust. The Council discharged its duties to the NHS through the section 31 agreement which provided for a Joint Advisory Board to oversee arrangements. The Care Home remained an in-patient service and its regulation was, therefore, the responsibility of the Healthcare Commission rather than the Commission for Social Care Inspection.

## Mr Hughes' care plan

316 The Council provided me with a copy of Mr Hughes' care plan. The care plan was written at the end of April 2004. It starts with a description of a 'normal day' written from Mr Hughes' point of view. This includes information about his activities of daily living and his behaviours. There are then seven specific care plans addressing a range of Mr Hughes' needs such as personal hygiene, communication, community orientation and management of his heart condition. Each section sets out an overall goal, care objectives and an action plan to meet those objectives.

## The Council's actions

317 After Mr Hughes' death the Council set up an inquiry under the Buckinghamshire Learning Disabilities Services' Serious Incident and Near Miss Policy. The remit of the inquiry was to investigate: the circumstances of Mr Hughes' first admission to the Trust; the circumstances of his discharge from the Trust; what specific discharge plan accompanied him and how that was followed by Care Home staff; the reason why he was accepted back at the Care Home; and first aid treatment provided by Care Home staff when he collapsed. The inquiry reported on 21 June 2004.

318 In response to my enquiries the Council explained why it had instigated an inquiry into events at the time of Mr Hughes' death, despite the fact that Mrs Keohane had not complained about the Care Home. The Council said that the investigation was a routine response to a 'Serious Incident'. It said:

*'It is uncommon for a resident of Mr Hughes' age to die in our services and the fact that this death occurred during a period in which he had been admitted to hospital was a further cause for concern.'*

319 I have seen a copy of the evidence collected for the inquiry as well as a copy of the detailed report of the investigation. The Council also provided me with an update on actions taken in response to the inquiry's recommendations. The Council told me the outcomes of the investigation had been shared with Mrs Keohane, the Mental Health Trust and the Trust and had been used to inform initiatives such as the joint Admission and Discharge Policy. The Council informed me that the findings of its inquiry had been shared with senior staff at the Trust in meetings on 3 September and 14 November 2004 and that discussion at the second meeting had been the catalyst for the joint Admission and Discharge Policy. I have seen a copy of the latter policy and a copy of the Operational Policy for the Care Home which includes responses to the report.

### Key events

320 The events complained about by Mrs Keohane concern the actions of the Care Home staff from the point when Mr Hughes was discharged to their care from the Trust at around 8.00pm on 26 May 2004 to his collapse the following day.

321 The key evidence about what happened to Mr Hughes in the period between his arrival home and his death less than 24 hours later is provided by contemporaneous records from the Care Home and papers from the Council's inquiry. The Council's inquiry does not provide contemporaneous evidence. However, statements and information for the Council's

inquiry were collected and processed by 21 June 2004, which was within a month of Mr Hughes' death. Therefore, I consider the inquiry is a reasonably reliable source of evidence about events on 27 May 2004.

322 From available evidence, especially the Care Home records, we know that Care Home staff were very concerned about Mr Hughes right from the time he arrived back from the Trust. Their anxieties have been described in the sections of this report dealing with the assessment of whether Mr Hughes was safely discharged from the Trust and the consideration of the GP's actions. From contemporaneous records we know they ensured a member of staff was with him as much as possible (for example, he was provided with his own nurse during the night of 26/27 May 2004) and they appropriately asked a GP to visit because they were concerned about his condition. Their records also show their personal knowledge and understanding of Mr Hughes as an individual in their care. The nurse who cared for Mr Hughes during the morning of 27 May 2004 wrote:

*'Ted is really a changed person.'*

323 I have seen Mr Hughes' individual care plans and descriptions of his normal day at the Care Home, including his likes and dislikes, his personal habits and ways of understanding his behaviour. These documents were not specifically updated in the short time between Mr Hughes' discharge and his collapse, but progress notes indicate that staff were gathering information about his condition and attempting to meet his changing needs.

324 The information given to the Care Home staff by the Trust about arrangements for Mr Hughes' nutrition (or any other aspect of his care) was entirely inadequate. There is no record of any written instructions being given to Care Home staff about dietary arrangements. We know that some time during the afternoon or early evening of 26 May 2004 the Care Home staff were given verbal instructions by the Deputy Sister of the Ward about how to prepare Mr Hughes' meals and thicken his drinks. The Senior Charge Nurse at the Care Home made a contemporaneous record of the conversation in Care Home records. He said the Deputy Sister had told him Mr Hughes would be followed up by the speech therapist who had advised that *'he is to eat only blended cold food and ice cold drinks from the fridge with thickener added to it'*.

325 There are few entries in the Care Home notes about what Mr Hughes ate after he arrived home. The Team Leader caring for him overnight recorded that he had been given *'thickened up fluids'*. There is no contemporaneous record of what Mr Hughes ate and drank from the time the night staff went off duty in the morning of 27 May 2004 to the time when he ate his evening meal.

326 During the evening of 27 May 2004, after Mr Hughes had collapsed and been taken to hospital, the Senior Health Care Assistant who witnessed events recorded:

*'Ted had his evening meal purified [sic] using 309's blender. Thickened drink given. Ted remained seated in the dining area after his meal. Around 17.40, Ted walked through the dining room door (leading to the male corridor) and collapsed onto the floor vomiting. [A Senior Health Care Assistant] rushed to Ted and supported his head so that Ted's vomit was not going back in his*

*mouth. Ted could hardly breath [sic]. [A Senior Health Care Assistant] quickly called for assistance and [the Charge Nurse] called for an ambulance. [A Senior Health Care Assistant] and [a 'bank' assistant] quickly came to Ted's aid. Pillows were put under Ted's head. [A Senior Health Care Assistant] kept on talking to Ted and calling his name. Ted slowly got limp and lifeless. The ambulance crew were quick to arrive and took over from the staff. For several minutes the ambulance crew tried to revive Ted before taking him to A&E.'*

327 The Team Manager – Aylesbury Community Learning Disability Team (the Council's Investigator) carried out the Council's investigation. During the investigation he interviewed the Care Home staff who were on duty when Mr Hughes collapsed and died. He recorded their recollections in his report. I have studied the report of the investigation and the only significant additional information about events around the time of Mr Hughes' collapse is that Mr Hughes stayed in the dining room for about twenty minutes after he had finished his evening meal, which he ate fully, before he walked into the corridor.

328 The Council's Investigator noted that no first aid procedures were attempted by the Care Home staff *'apart from placing him in the semi-recovery position'*. He concluded that:

*'... given the complexity of Mr Hughes' health status, the difficulty of performing resuscitation with a person vomiting and the level of experience and training of the staff involved, this was entirely appropriate. They did all that they could under the circumstances and no more could have been done.'*

329 However, he also noted that even the senior staff at the Care Home had not received recent first aid training. The Charge Nurse on duty when Mr Hughes collapsed told the Council's Investigator that he had received no first aid training in the previous ten years. The Council's Investigator recommended that a plan for basic first aid training should be implemented at the Care Home, but he recommended caution around any decision to provide specialist first aid equipment, such as suction apparatus.

### The advice of the Local Government Ombudsman's Professional Advisers

330 My Professional Advisers have had the opportunity to study records from the Trust and the Care Home. The Care Home records contain Mr Hughes' detailed individual care plans, medication charts, daily progress reports and other papers directly related to his healthcare. They have also seen the report of the Council's inquiry.

331 My Speech and Language Therapy Adviser said she could find no written advice to Care Home staff about Mr Hughes' diet. Having looked at records from the Trust and the Care Home she said:

*'I can only find a telephone discussion with the ward sister documented, who verbally handed over some eating and drinking recommendations for Mr Hughes, which were not entirely accurate.'*

332 My Speech and Language Therapy Adviser said she found it difficult to comment on how the Care Home staff interpreted dietary advice from the Trust because they were 'given very little instruction'. She noted that, for example, the Trust had not advised the Care Home about the appropriate texture of Mr Hughes' food or drinks.

333 My Anaesthetic Adviser said:

*'An immediate impression is gained of a culture of caring and concern at 309 Cressex Rd. There are entries for each day of Ted's admission giving advice and on several occasions physically helping care for him on the urology ward. During his stay on ITU the home contacted the hospital each day and the level of care and interest is akin to that of a caring relative.'*

334 There were some differences of view amongst my Professional Advisers about whether or not the Care Home staff should have attempted basic cardiopulmonary resuscitation when Mr Hughes collapsed.

335 My Anaesthetic Adviser said, given the level of training and experience, the Care Home staff acted reasonably when Mr Hughes collapsed. He said:

*'As a residential home I am sure that there would be no shortfall in duty of care if they could not give more than basic life support.'*

336 My Learning Disability Adviser said:

*'It must be remembered that the staff dealing with the incident were Mental Health Nurses and not trained Adult Acute Nurses.'*

*'...'*

*'I feel that under the circumstances the staff at 309 Cressex Road did all that they could to help Mr Hughes given limited resources.'*

## The Local Government Ombudsman's findings

- 337 Mrs Keohane did not raise her concerns until October 2007 because her understanding of what happened to Mr Hughes has evolved as the complaints process has progressed. I can fully understand why she now wants to know what actions the Care Home staff took when Mr Hughes was discharged from the Trust and whether their actions had any influence on his death.
- 338 I have considered evidence from various sources about the actions of the Care Home staff and I have not found any significant inconsistencies in the relevant documents and accounts available to me. However, I note the 'story' about what happened around the time when Mr Hughes collapsed has changed over time and some of the known facts about events have become somewhat distorted. I have considered the advice of my Professional Advisers who have made a detailed study of the available evidence.
- 339 In assessing the actions of the Care Home staff I have taken account of relevant legislation and standards. In particular, I have referred to the requirements set out in Valuing People and the Code of Conduct.
- 340 First, it is clear to me that the Care Home staff were very concerned about Mr Hughes' welfare. I have seen evidence, particularly in the personalised and the Care Home records, that they had a professional understanding of his needs, a commitment to meeting those needs and a genuine concern for his welfare as a long-term resident in their care. My Anaesthetic Adviser remarked on the level of care and concern shown for Mr Hughes by the Care Home staff while he was a patient in the Trust. During this time they also kept in contact with Mrs Keohane.
- 341 In the short time between Mr Hughes' discharge from the Trust and his collapse the Care Home staff were very concerned about his welfare and safety. This is clearly demonstrated in their actions, such as arranging one-to-one care and contacting the GP, and their reports and assessment of his condition.
- 342 The evidence I have seen shows the Care Home staff were committed to the values and standards, especially the person-centred approach, described in documents such as Valuing People.
- 343 Secondly, I consider the instructions which the Care Home staff received about Mr Hughes' diet and the way they interpreted those instructions. I have seen no evidence that the Care Home staff received clear instructions from the Trust about how to prepare food and drinks for Mr Hughes. No written instructions were provided either by the Trust nurses or the speech and language therapy team. The Speech and Language Therapy Adviser has pointed out that the instructions written in the Care Home record by the Care Home Senior Charge Nurse following his conversation with the Deputy Sister at the Trust do not precisely match the instructions written in the Trust record by the speech and language therapist who saw Mr Hughes before he was discharged. I cannot say whether the Senior Charge Nurse was not given the correct instructions or whether he misinterpreted the information which was given to him. However, I note that the Care Home staff were alert to the importance of providing Mr Hughes with the correct diet because when they contacted the Surgery on 27 May 2004 they asked for drinks thickener to be prescribed for him. What I can say is that the Trust should have provided the Care Home with written information about Mr Hughes' diet and it was a failing on the part of the Trust (not the Care

Home) which led to any uncertainty about how to prepare his food and drinks.

344 The Care Home records do not give details of all the food and drinks which Mr Hughes consumed after his discharge. However, I consider there is enough information (in the record that he was given thickened drinks during the night of 26/27 May 2004 and his evening meal was puréed and he had a thickened drink on 27 May 2004) to show that Care Home staff were alert to the possibility that he might aspirate. The evidence also suggests Care Home staff took measures which were broadly in line with the imprecise verbal instructions they had received. In my view, given the limited instructions they had received, there is sufficient evidence to show the Care Home staff acted reasonably in managing Mr Hughes' diet.

345 I note that with the passage of time information about Mr Hughes' last meal has become distorted and this may have led in part to Mrs Keohane's concern about the actions of the Care Home staff. From complaint correspondence and Death by *indifference* we know Mencap and Mrs Keohane understood Mr Hughes ate a communal meal then got up, vomited and collapsed. In my view, this version of events implies that Mr Hughes ate the same meal as his fellow residents and very soon afterwards he vomited, inhaled food and died. I am clear that this was not the case. Although we cannot know exactly what Mr Hughes ate and there is little evidence about the texture and consistency of his meal, we do know from a contemporaneous entry in the Care Home record that his evening meal was puréed and his drink thickened. Furthermore, the evidence is that he did not vomit and collapse immediately after the meal, but some twenty minutes later. The evidence of the contemporaneous

record made by staff who were present when Mr Hughes' evening meal was prepared and eaten and when he collapsed suggests to me that the actions of the Care Home staff did not have any influence on his subsequent collapse and death.

346 Finally, I turn to the question of whether Care Home staff acted appropriately and reasonably when Mr Hughes collapsed. My Anaesthetic and Learning Disability Advisers said that, given the fact that staff apparently had no first aid or basic life support training, those present when Mr Hughes collapsed acted responsibly and reasonably. It is not clear whether or not Mr Hughes was turned into the 'recovery position' (lying face down with his head turned to the side and his upward-facing limbs bent) which is the recommended manoeuvre for anyone who had unexpectedly collapsed. The contemporaneous record describes how staff supported Mr Hughes' head to try and stop him inhaling vomit. In later descriptions, for example in the inquiry report, it is said that Mr Hughes was placed in a '*semi recovery position*', although it is not clear precisely what is meant by this. What is clear is that Care Home staff knew they should try and prevent Mr Hughes inhaling vomit and they attempted to stop this happening. In my view it would not have been appropriate for staff who had not been trained in cardiopulmonary resuscitation techniques to attempt to resuscitate Mr Hughes. I find that they acted appropriately and reasonably in calling for an emergency ambulance as soon as they realised the seriousness of the situation.

347 That said, I was concerned to learn that senior Care Home staff had apparently received little or no training in first aid. Given that they were responsible for a group of vulnerable adults

as well as a group of mostly unqualified staff, I find it was unacceptable that the senior staff had neither received, nor sought, training in first aid. I find this was an organisational failing because I would have expected basic first aid training to have been organised in the Care Home environment to allow staff to practise safely. I find the senior nurses at the Care Home should have taken personal professional responsibility for ensuring they were adequately trained. Their Code of Conduct stated that, as qualified nurses, they were responsible for their actions and omissions. However, I note that this failing has now been appropriately addressed as a result of the Council's inquiry. I have been assured that first aid training is now mandatory for all staff and this is regularly monitored, for example, through training records.

### Complaint against the Council: the Local Government Ombudsman's conclusion

348 I conclude that the service provided to Mr Hughes by the Care Home staff after he was discharged from the Trust on 26 May 2004 was reasonable in the circumstances. I consider they acted broadly in accordance with national and professional guidelines on caring for patients with particular needs. I have taken into account the limited instructions which they had received from the Trust and their lack of first aid training and I find no reason to criticise their actions, decisions or attitudes regarding their care and treatment of Mr Hughes at and around the time of his death. I note that appropriate action has been taken to remedy the failing I identified regarding first aid training.

349 I conclude that any shortcomings which I have identified **do not amount to maladministration** by the Council. Therefore, I **do not uphold** Mrs Keohane's complaint against the Council.

350 At this point I would like to commend the Council's response to Mr Hughes' unexpected death. Although there was no complaint about the Care Home, the Council quickly instigated a thorough investigation of events and produced a detailed report aimed at learning lessons and improving services. I have seen evidence that it appropriately shared the learning from its investigation with partner organisations and with Mrs Keohane. I have also seen evidence about the actions taken as a result of that investigation which demonstrates that the Council has followed up on the recommendations made as a result of its investigation.

### The Health Service Ombudsman's investigation of the complaint against the Healthcare Commission

#### Complaint (g): the Healthcare Commission's review of Mrs Keohane's complaints against the Trust and the Surgery

351 Mrs Keohane is dissatisfied with the way the Healthcare Commission (the Commission) handled her complaint. She says the Commission's reviews took too long and did not provide her with the explanations she sought.

#### The basis for the Health Service Ombudsman's determination of the complaints

352 The regulations and standards which apply to the Commission's handling of complaints are set out in Section 2 of this report. When assessing the way the Commission handled Mrs Keohane's complaint I have regard to those regulations and standards and to my own *Principles of Good Administration* and *Principles for Remedy*.

## The Health Service Ombudsman's jurisdiction and role

- 353 Section 1 of this report sets out the basis of my jurisdiction in relation to complaints made to me that a person (or body) has sustained injustice or hardship in consequence of maladministration by the Commission in the exercise of its complaint handling function.
- 354 When complaints have already been reviewed by the Commission, I do not normally carry out an investigation of the original complaint, but investigate the way in which the Commission has conducted its review. Specifically, I consider whether:
- i. there were any flaws in the Commission's review process which make the decision unsafe;
  - ii. the Commission's decision at the end of the review process was reasonable; and
  - iii. the service the Commission provided was reasonable and in line with its own service standards.

355 When I uphold a complaint about the Commission's complaint handling, because I find that the review process was flawed, or the decision unreasonable, I normally refer the complaint back to the Commission for it to remedy the failure by conducting a further review.

## The Health Service Ombudsman's decision

356 Mrs Keohane made two separate complaints to the Commission. Her first complaint was against the Trust, and following completion of the Commission's review of that complaint,

she made a second complaint against the Surgery. For the reasons given below, I **uphold** Mrs Keohane's complaint about the Commission's handling of her complaint against the Trust. However, I did not consider it appropriate to recommend a further review by the Commission and I therefore decided to investigate the complaint myself.

357 I **do not uphold** Mrs Keohane's complaint about the Commission's handling of her complaint against the Surgery.

## The Commission's review of Mrs Keohane's complaint against the Trust

### Key events

358 Mrs Keohane complained to the Commission on 11 May 2005, ten months after the Trust had responded to her complaint. The Commission initially decided that her complaint was out of time. However, Mrs Keohane subsequently contacted the Commission on 18 October 2005 to explain why she had not complained to it earlier, and, on 31 October 2005, the Commission informed her that it had agreed to accept her complaint for review.

359 Mrs Keohane's complaints were that:

- the Trust had failed in duty of care to Mr Hughes, given that he had fallen out of bed after his operation; and
- his discharge had been premature and inappropriate given his needs.

360 The Commission made no further contact with Mrs Keohane until 28 March 2006 when it apologised for the delay in allocating her case for review. On 12 April 2006 one of the Commission's Case Managers wrote to

Mrs Keohane to inform her that she would be responsible for reviewing her case and to explain how she would undertake her review. Mrs Keohane was, from that point onwards, kept regularly updated with the progress of her complaint.

- 361 The Commission did not take any clinical advice as part of its review.

#### *The Commission's decision*

- 362 On 21 June 2006 the Commission reported on Mrs Keohane's complaint. It concluded that the Trust's response to Mrs Keohane was inadequate and referred both aspects of her complaint back to the Trust for further local resolution. The Commission said that the Trust's response had *'failed to provide a complete and accurate picture and the statements and the investigation they undertook failed to bring to light issues which came out at the inquest'*. The Commission criticised the Trust for only mentioning one fall and failing to disclose the second and said that the Trust's investigation had not uncovered the fact that there was *'clear evidence that concerns were raised [by Trust staff] about the appropriateness of Ted's discharge'*. The Commission recommended that the Trust revisit Mrs Keohane's complaint. The Commission also made two further general recommendations about how the Trust should handle a complaint where an inquest had been held.
- 363 The Trust did not respond to the Commission's recommendations for nine months. There is no evidence to suggest that the Commission took any action during this period to follow up its recommendations.

#### **The Health Service Ombudsman's findings**

- 364 I have explained that I assess the way in which the Commission conducted its review by considering the review process, the decision and whether the service provided was reasonable.
- 365 I find that the Commission's decision that the Trust's response was inadequate was a reasonable one. I see no flaws in the process by which the Commission reached this decision. It reviewed the evidence and, rightly in my view, concluded that the Trust had failed to address the issues Mrs Keohane had raised. In particular, the Trust had failed to take account of the concerns expressed by staff regarding Mr Hughes' discharge. The Commission concluded the Trust's assessment of all the relevant available evidence was inadequate and, as such, that the Trust's response was unsound. In the light of this conclusion, the Commission did not go on to make any clinical determination of the substantive issues, deciding instead to refer the case back to the Trust to address the identified failings. This is an action which it has discretion to take.
- 366 I am, however, critical of the fact that there is no evidence to suggest that the Commission made any effort to follow up its recommendations to the Trust. The Commission had made significant criticisms of the Trust and, as it appears to have recognised, Mrs Keohane's complaint raised serious issues. In these circumstances, I consider the Commission should have followed up its recommendation that Mrs Keohane should receive a timely and satisfactory response from the Trust.

367 I also find that the service which the Commission provided was poor. The Commission's service standard at the time was that, in the majority of cases, the review process should take no longer than six months. The Commission took eight months to complete its review. Whilst I do not consider that this length of time would, in the circumstances, amount to poor service, I was concerned to note that the Commission did not make any contact with Mrs Keohane for a period of five months. One of the six *Principles of Good Administration* (referred to in Section 2 of this report) is that public bodies should be customer focused and, specifically, that they should deal with people helpfully and sensitively bearing in mind their individual circumstances. Failing to have made any contact with Mrs Keohane for such a significant period of time does not reflect good administrative practice or customer service.

368 I conclude that the failings I have identified in the Commission's handling of Mrs Keohane's complaint against the Trust amount to **maladministration**.

### Injustice

369 The injustice arising from the Commission's maladministration is that Mrs Keohane's complaints about the Trust were not afforded the serious consideration which they warranted. She did not receive the answers she sought or get the proper review of her complaints to which she was entitled. She was also left, for a significant period of time, without any information about the progress of her complaint.

370 Therefore, I **uphold** this aspect of Mrs Keohane's complaint against the Commission.

### The Health Service Ombudsman's recommendation

371 I **recommend** that the Commission apologise to Mrs Keohane for failing to carry out a proper review of her complaint against the Trust.

372 The Chief Executive has accepted my recommendation and she will write to Mrs Keohane to express her apologies once the final report has been issued.

### The Commission's review of Mrs Keohane's complaint against the Surgery

#### *Key events*

373 On 16 August 2006 Mencap, on behalf of Mrs Keohane, complained to the Commission about the GP's actions when he visited Mr Hughes at the Care Home on 27 May 2004. Mrs Keohane was concerned about the way the GP reached his decision not to admit Mr Hughes to hospital. She believed that had the GP admitted Mr Hughes, his subsequent collapse and death might well have been avoided. On 8 September 2006 Mencap added a further point to the complaint. They said the GP had taken too long to respond to the request to visit Mr Hughes.

374 Mrs Keohane's complaint about delay in the GP's visit to the Care Home had not been raised previously with the Surgery. Therefore, in accordance with the Regulations which govern the NHS Complaints Procedure, the Commission could have referred it to the Surgery for them to respond in the first instance. However, in order to provide Mrs Keohane with a comprehensive response to her complaints, the Commission decided to incorporate both elements into its review.

375 The Commission took clinical advice. The Commission's Clinical Adviser did not consider that there had been any undue delay on the GP's part on 27 May 2004 in responding to what appeared to be a non-urgent request. He also concluded the GP's decision not to admit Mr Hughes to hospital at that time was reasonable. He did not think there was any further action that the GP should have taken and he considered his actions had been appropriate.

376 My GP Adviser has advised that the clinical advice which the Commission received was provided by an appropriately qualified clinician and that the decisions which the Commission's Adviser reached were reasonable.

#### *The Commission's decision*

377 On 30 November 2006 the Commission reported on Mrs Keohane's complaint. The Commission concluded that the care and treatment which Mr Hughes had received had been appropriate and that no further action was warranted.

### **The Health Service Ombudsman's findings**

378 I have explained that I assess the way in which the Commission conducted its review by considering the review process, the decision and whether the service which it provided was reasonable.

379 I have found no fault in the Commission's review of Mrs Keohane's complaint against the Surgery. Because one part of Mrs Keohane's complaint to the Commission, the timing of the GP's visit on 27 May 2004, had not been considered by the Surgery, it was open to the Commission to have referred it back to the Surgery in the first instance. However, in order to provide

Mrs Keohane with a full response to her complaint, the Commission decided instead to incorporate both parts of her complaint into its review. One of the six *Principles of Good Administration* (referred to in Section 2 of this report) is that public bodies should be customer focused, and specifically that they should deal with people helpfully and sensitively bearing in mind their individual circumstances. The approach which the Commission took in this part of its review reflects good administration and customer service.

380 I would expect that when the Commission reviews complaints which involve clinical matters, it would obtain appropriate advice from professional advisers with relevant experience and expertise. I am satisfied that the Commission's Adviser was appropriately qualified and had the relevant experience and expertise. I am also satisfied that the Commission's decision, which was made on the basis of that advice, was reasonable.

381 The Commission completed the review within three months which is within the service standard prevailing at the time.

382 I conclude that there is **no evidence of maladministration** in respect of the Commission's review of Mrs Keohane's complaint against the Surgery.

383 Therefore, I **do not uphold** this aspect of Mrs Keohane's complaint against the Commission.

## Section 4: the Ombudsmen's final comments

### Introduction

- 384 Mrs Keohane's overarching complaint is that Mr Hughes' death was avoidable and that he was treated less favourably for disability related reasons. She told us she has not had answers to all her questions and she hopes the Ombudsmen's investigation will provide her with those answers. She also hopes that other people will not go through the same experience as Mr Hughes. In this final section of our report we address Mrs Keohane's overarching complaint.
- 385 In assessing the actions of the Trust, the Surgery, the Council and the Healthcare Commission we have taken account of relevant legislation and related policy and administrative guidance as described in Section 2 of this report. We have taken account of available evidence and considered the advice of our Professional Advisers.

### Was Mr Hughes treated less favourably for reasons related to his learning disabilities? The Health Service Ombudsman's conclusions

- 386 Mrs Keohane believes her brother was treated less favourably for reasons related to his learning disabilities.
- 387 I have found service failure in respect of the inadequate care and treatment provided by the Trust to Mr Hughes following his transfer from the ICU to the Ward. In particular, I have concluded that the Ward nurses made entirely inadequate attempts to assess Mr Hughes' needs, and to plan and deliver care for him, following his transfer from the ICU. The arrangements for his discharge were inadequate and the Trust discharged him when it was not safe to do so.
- 388 I have also concluded that these failures in Mr Hughes' care and treatment were for disability related reasons. The Trust had not ensured that appropriate arrangements were in place for the care and treatment of people with learning disabilities. Also, the Ward nurses did not assess Mr Hughes' needs adequately, or at all, nor did they plan or deliver adequate care for him. The discharge arrangements were also inadequate for disability related reasons. Mr Hughes' behaviour, which was linked to his impairment, made him difficult to manage on the Ward and this encouraged staff to move him on. In Mr Hughes' case, and for reasons related to his impairment, there was particular need to convey to the receiving Care Home specific information about his condition and future care. This did not happen.
- 389 In Section 2 I set out my approach to human rights. On that basis, I also conclude that the Trust's actions and omissions constituted a failure to live up to human rights principles, especially those of dignity and equality.
- 390 By discharging Mr Hughes prematurely and without sufficient regard to his care, the Trust failed to have due regard to the need to safeguard his dignity and wellbeing in his future care by the Care Home, and to the observance of the principle of equality in the delivery of his care. There is no evidence of any positive intention to humiliate or debase Mr Hughes. Nevertheless, the standard of service does raise the question whether the Trust's actions constitute a failure to respect Mr Hughes' dignity.
- 391 In these respects, I conclude the service failures I have found demonstrated inadequate respect for Mr Hughes' status as a person.

## Was Mr Hughes' death avoidable? The Ombudsmen's conclusions

- 392 Mrs Keohane believes that had her brother received appropriate and reasonable care from the Trust, the Surgery and the Council his death would have been avoided.
- 393 In considering whether to make a finding about avoidable death we assess whether the injustice or hardship complained about (in this case Mr Hughes' death) arose in consequence of the service failure or maladministration we have identified.
- 394 Mrs Keohane has told us she feels even after the inquest, the responses from the bodies complained about and the Healthcare Commission's reviews, she has not had a clear explanation about why her brother died. She remains concerned that Mr Hughes' death was avoidable. She asks the Ombudsmen whether they could help her understand what is likely to have happened to cause Mr Hughes to collapse when he died. To this end, she specifically asks whether there is anything in the A&E records relating to Mr Hughes' death.

## Events when Mr Hughes collapsed

- 395 There is limited information available about Mr Hughes' death. However, we have looked at records made by the Care Home staff, the ambulance crew, A&E staff and the pathologist. We also sought additional information from the Coroner.

- 396 We know from the contemporaneous Care Home records which were made by the nurse who witnessed Mr Hughes collapse that at 5.40pm, around twenty minutes after eating a puréed meal, Mr Hughes got up and walked out of the dining area. The nurse recorded that Mr Hughes unexpectedly fell to the floor, hit his head and vomited. We also know from the ambulance record that when the ambulance crew reached Mr Hughes at 5.54pm his heart had stopped and, despite resuscitation attempts by the crew and staff in A&E, it could not be restarted.

## The post mortem report

- 397 The Coroner ordered a post mortem to be performed. The pathologist who examined Mr Hughes' body made a series of detailed observations which she recorded in her report. Of specific relevance are the sections of her report relating to Mr Hughes' brain, lungs and heart.
- 398 The pathologist said there was no evidence in Mr Hughes' brain that suggested he had suffered a stroke. She also said that there was no evidence in his heart that he had suffered a heart attack. However, she did note that both ventricles (the lower chambers of the heart) were enlarged and there were some degenerative changes of two of the heart valves.
- 399 The pathologist found no clots in Mr Hughes' lungs. She found no bolus of food in the back of his throat, but she did find '*a large amount of partly digested food*' in the upper windpipe. She also found partly digested food in the respiratory passages leading into some areas of the lung tissue itself.

400 The pathologist concluded that Mr Hughes' heart showed evidence of heart failure (this is failure of the heart to pump adequately, not a heart attack) and cardiomyopathy (disease causing weakening of the cardiac muscle itself), but no evidence of a heart attack. She also concluded that there was some evidence that Mr Hughes had previously suffered from pneumonia although she saw no signs of acute pneumomonia. She said:

*'Continual aspiration of stomach contents over a prolonged period of time would have led to pulmonary [lung] damage with subsequent organising pneumonia leading to deteriorating lung function and eventual death. Coexistent heart failure would have accelerated death.'*

401 In other words, probably principally on the basis of her examination of Mr Hughes' body, the pathologist concluded that he had died because he had been aspirating food over a period of time and this chronic problem, along with his heart failure, had led to pneumonia and death.

## The Coroner's inquest

402 Where there is to be a Coroner's inquest, no death certificate is issued until the Coroner has determined the cause of death. It is the role of the Registrar of Births, Marriages and Deaths to issue the death certificate after the inquest. The Coroner has confirmed to us that he recorded a verdict of natural causes and notified the Registrar that the cause of death was acute on chronic aspiration. In Death by *indifference* Mencap said Mr Hughes' death certificate said he had died from a heart attack, but this was changed after the inquest to aspiration pneumonia. Unfortunately, this is not correct as the death certificate did not mention

a heart attack. The Coroner told us that having considered the evidence before him, including the pathologist's report which concluded that the causes of death were organising pneumonia and chronic aspiration, he decided that there was evidence to suggest that Mr Hughes had aspirated at the time of his death. This is why he instructed the Registrar that the cause of death was acute on chronic aspiration.

## The opinion of the Ombudsmen's Professional Advisers

403 Our Anaesthetic Adviser said there is nothing in the A&E record of 27 May 2004 which sheds light on Mr Hughes' death. He said the record only shows that Mr Hughes' heart had stopped and that attempts to revive him were unsuccessful.

404 Our Anaesthetic Adviser told us about the most frequent reasons why an adult of Mr Hughes' age suddenly collapses and dies. He said that in these circumstances sudden death (when there is no accident or injury) is usually the result of either a stroke, a pulmonary embolism (where a blood clot blocks a major blood vessel or group of vessels in the lungs) or a cardiac event, such as a heart attack or significant change in heart rhythm. Our Anaesthetic Adviser said that a change in heart rhythm results from abnormal electrical impulses passing through heart muscle. This adversely affects the normal heart beat and may cause the heart to stop, but does not result in a change to heart muscle itself. Therefore, a change in heart rhythm cannot be detected at post mortem examination.

405 Our Anaesthetic Adviser explained that when a fully conscious adult vomits the natural body movements (for example, leaning forward) together with mechanisms in the throat, automatically stop them inhaling large amounts

of food which would otherwise cause them to choke and inhibit their breathing. He explained that it is only when a person is partly or fully unconscious that they cannot protect their respiratory system in this way. Our Anaesthetic Adviser said we know from the post mortem that Mr Hughes aspirated food into his upper windpipe before he died and, therefore, it follows that something must have caused Mr Hughes to lose consciousness before he vomited.

406 Our Cardiology and Anaesthetic Advisers do not dispute that Mr Hughes vomited and aspirated when he died. However, they have suggested that, given the information they have seen about events on 27 May 2004, especially the facts that 20 minutes had passed since Mr Hughes ate his evening meal and he was conscious and walking out of the dining room before he vomited, it is unlikely that the episode of vomiting was the direct cause of his collapse.

407 Both Advisers said they can only speculate in hindsight about what may have caused Mr Hughes to collapse. However, given Mr Hughes' history of problems with his heart rhythm, they suggested it is possible that an unexpected and unpredictable alteration in heart rhythm (which may have stopped his heart beating) caused him to collapse suddenly, vomit, aspirate, stop breathing and die. They agreed that if this is what occurred, there is nothing that could reasonably have been done to prevent him collapsing, or to save his life once he had collapsed. The Anaesthetic Adviser emphasised that if Mr Hughes had suffered this sudden change in his heart rhythm the Coroner would not have had evidence of the event because it would not have been detectable at the post mortem.

## The Ombudsmen's finding

408 Mrs Keohane has asked whether we could find any additional information about the reason why Mr Hughes collapsed and died. We should make it clear that it is not possible to establish beyond doubt why Mr Hughes collapsed. We have not found any evidence which points directly to a cause for his collapse. As we have said, there is no post mortem evidence which shows he collapsed due to any of the most common causes of collapse for a person of his age. That said, in the light of the advice from our Cardiology and Anaesthetic Advisers, it does seem possible to us that he collapsed due to a sudden change in his heart rhythm which led to the other events associated with his death.

409 We hope Mrs Keohane may be able to take some comfort from the knowledge that it is likely nothing could have been done to prevent Mr Hughes collapsing and that the likelihood that Mr Hughes would have survived such an event, even in hospital, would have been low.

410 Our Professional Advisers have studied the evidence available to them and given their view about the likely cause of his collapse. However, we have not concluded that Mr Hughes' death occurred in consequence of any maladministration or service failure which we have found in the course of our investigation and, therefore, we do not conclude that his death was avoidable.

## Mrs Keohane's response to the Ombudsmen's draft report

411 Mrs Keohane said trying to find out what had happened to her brother had been a '*long, frustrating and distressing time*'. She said our

investigation into Mr Hughes' death was thorough and at last enables his family to have a better understanding of what happened to him. She said it was a comfort to her to have the story clarified and presented so clearly. She also found comfort in the information provided about the standard of care in the Care Home.

412 However, Mrs Keohane does not accept the suggestion about the reason for her brother's collapse which has been put forward by our Professional Advisers. She feels strongly that he was prematurely discharged from the Trust and the GP should have readmitted him to hospital. She believes Mr Hughes collapsed because he vomited, choked and stopped breathing. In particular, she does not accept the Health Service Ombudsman's conclusion that there was no service failure in the care and treatment provided by the GP.

413 In response to Mrs Keohane's concerns the Health Service Ombudsman reviewed the available information about the GP's actions in the light of the professional advice she had received. However, the advice which she received was unequivocal and she found no new evidence which would cast doubt on her findings and decision on this matter.

414 Mrs Keohane also asked for a more detailed explanation about the mechanism of aspiration. In response our Anaesthetic Adviser provided further advice which is included above.

416 We acknowledge that Mrs Keohane does not agree with all of our findings and decisions. However, we can assure her that her complaints have been thoroughly and impartially investigated and that our conclusions have been drawn from careful consideration of detailed evidence, including the opinion of independent professional advisers.

417 We hope our report will provide her with the explanations she seeks and reassure her that lessons have been learnt and learning shared as a result of her complaint so others are less likely to suffer the same experiences as her and her brother. We also hope our report will draw what has been a long and complex complaints process to a close.



Ann Abraham  
**Parliamentary and Health Service Ombudsman**



Jerry White  
**Local Government Ombudsman**

## The Ombudsmen's concluding remarks

415 In earlier sections of this, our joint report, we have set out our investigation and findings with regard to the care and treatment and service Mr Hughes and his sister received from the Council, the NHS and the Healthcare Commission.

March 2009

# ANNEX A

## Good Medical Practice, 2001: relevant sections

### The duties of a doctor

*'Patients must be able to trust doctors with their lives and well-being. To justify that trust, we as a profession have a duty to maintain a good standard of practice and care and to show respect for human life. In particular as a doctor you must:*

- *make the care of your patient your first concern;*
- *treat every patient politely and considerately;*
- *respect patients' dignity and privacy;*
- *listen to patients and respect their views;*
- *give patients information in a way they can understand;*
- *respect the rights of patients to be fully involved in decisions about their care;*
- *keep your professional knowledge and skills up to date;*
- *recognise the limits of your professional competence;*
- *be honest and trustworthy;*
- *respect and protect confidential information;*
- *make sure that your personal beliefs do not prejudice your patients' care;*

- *act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practise;*
- *avoid abusing your position as a doctor; and*
- *work with colleagues in the ways that best serve patients' interests.*

*In all these matters you must never discriminate unfairly against your patients or colleagues. And you must always be prepared to justify your actions to them.'*

### Providing a good standard of practice and care (sections 2 and 3)

*'Good clinical care must include:*

- *an adequate assessment of the patient's conditions, based on the history and symptoms and, if necessary, an appropriate examination;*
- *providing or arranging investigations or treatment where necessary;*
- *taking suitable and prompt action when necessary;*
- *referring the patient to another practitioner, when indicated.*

*'In providing care you must:*

- *recognise and work within the limits of your professional competence;*
- *be willing to consult colleagues;*

- *be competent when making diagnoses and when giving or arranging treatment;*
- *keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed;*
- *keep colleagues well informed when sharing the care of patients;*
- *provide the necessary care to alleviate pain and distress whether or not curative treatment is possible;*
- *prescribe drugs or treatment, including repeat prescriptions, only where you have adequate knowledge of the patient's health and medical needs. You must not give or recommend to patients any investigation or treatment which you know is not in their best interests, nor withhold appropriate treatments or referral;*
- *report adverse drug reactions as required under the relevant reporting scheme, and co-operate with requests for information from organisations monitoring the public health;*
- *make efficient use of the resources available to you.'*

## Working with colleagues (section 36)

*'Healthcare is increasingly provided by multi-disciplinary teams. Working in a team does not change your personal accountability for your professional conduct and the care you provide. When working in a team, you must:*

- *respect the skills and contributions of your colleagues;*
- *...*
- *communicate effectively with colleagues within and outside the team.'*

## ANNEX B

### Discharge from hospital: pathway, process and practice

The 'key messages' for all agencies involved in admission and discharge were:

- *'Understand your local community and balance the range of services to meet health, housing and social needs.'*
  - *'Ensure individuals and their carers are actively engaged in the planning and delivery of their care.'*
  - *'Recognise the important role carers play and their own right for assessment and support.'*
  - *'Ensure effective communication between primary, secondary and social care to ensure that prior to admission and on admission each individual receives the care and treatment they need.'*
  - *'Agree, operate and performance manage a joint discharge policy that facilitates effective multidisciplinary working between organisations.'*
  - *'On admission, identify those individuals who may have additional health, social and/or housing needs to be met before they can leave hospital and target them for extra support.'*
  - *'At ward level, identify and train individuals who can take on the role of care co-ordination in support of the multidisciplinary team and individual patients and their carers.'*
- *'Consider how an integrated discharge planning team can be developed to provide specialist discharge planning support to the patient and multidisciplinary team.'*
  - *'Ensure all patients are assessed for a period of rehabilitation before any permanent decisions on care options are made.'*
  - *'Ensure that the funding decision for NHS continuing care and care home placement are made in a way that does not delay someone's discharge.'*

The workbook contained two sections specifically about care for people with learning disabilities.

Section 5.6 draws attention to some of the common problems experienced by people with learning disabilities in an acute hospital setting. These include communication, consent, open ward environments and:

*'the emphasis on rapid discharge limiting the time for thorough assessment and people's full needs are not always identified or treated. They may return to the community, or institutional care, with needs still not met; and*

*'care plans being made without vital information being obtained from those health, social care, family carers or housing services that are aware of their needs and current difficulties.'*

Section 5.6 also draws attention to common difficulties for acute hospital services which may lead to incomplete and unrealistic discharge planning. These include poor links between acute and specialist mental health liaison services, delay in obtaining expert advice, and other patients' feelings about patients displaying agitation or challenging behaviour.

Section 5.6 includes suggestions for actions to be taken by commissioners, managers and practitioners to improve discharge planning for people with learning disabilities. It says that managers may wish to consider:

*'supporting the provision of training for acute staff in issues of consent, basic mental health, dealing with people who are confused and the impact of having a learning disability on physical functioning and communication;*

*'developing protocols or guidelines for dealing with both emergency and planned admissions and presentations at A&E ... ;*

*'providing active support and time for practitioners from learning disability and mental health teams to support individuals when in acute and physical health care sector; ...'*

Practitioners may wish to consider:

*'... looking at each patient as an individual and understand the anxieties he or she may have and working with staff in specialist services to alleviate these;*

*'actively seeking the involvement of families and/or professional health or social care staff.'*

Section 5.7 reminds hospitals of best practice with regard to people with learning disabilities including: preparing for admission, through making contact with the patient, reducing patient anxiety and involving the community team and GPs; using the hospital workbook; for an emergency admission, supporting and contacting parents and carers, using the hospital handbook, considering waiting areas and possibly fast-tracking patients through A&E; and for admission to the ward, providing ongoing support and extra time for communication.

## ANNEX C

### Sequence of key events during Mr Hughes' stay in the Trust

#### **5 May 2004**

Mr Hughes was admitted to the Trust suffering from a distended abdomen. He was found to be in urinary retention and was catheterised to allow urine to flow from his bladder and relieve his discomfort. When he was admitted he was taking drugs for his heart condition and anti-acid medicine to treat excess acid in his stomach.

#### **12 May 2004**

Mr Hughes could not tolerate the catheter so doctors could not follow the usual treatment pathway for his enlarged prostate. Normally patients with this condition would have been discharged home with a urinary catheter and readmitted at a later date for planned surgery. Therefore, Mr Hughes was treated as an urgent patient and part of his prostate gland was surgically removed. He returned to the Ward after his surgery.

#### **16 May 2004**

At 2.30am Mr Hughes fell on the floor while returning to bed. He sustained a laceration near his eyebrow. At this time, observations of his nervous system and circulation appeared stable but he had been suffering vomiting and diarrhoea. He was seen by two junior doctors. By 10.00am his condition had deteriorated. His blood pressure could not be recorded and the extremities of his body were cold. An anaesthetist saw him and admitted him to the ICU. When he arrived in the ICU Mr Hughes was found to have low blood pressure, he was agitated, breathing quickly and the levels of oxygen in his blood were low. The number of white cells in his blood was very high.

#### **17 to 19 May 2004**

By this time Mr Hughes had been connected to a ventilator and was receiving intravenous drugs to maintain his blood pressure. A troponin level was recorded as 2.5 which suggested that something had happened to his heart, possibly a heart attack.

#### **21 May 2004**

Blood and urinary infections were being treated and he was suffering respiratory problems.

#### **22 to 24 May 2004**

Mr Hughes gradually recovered. He needed less medication to support his blood pressure and the ventilator was disconnected. By 24 May the ICU doctors had decided that Mr Hughes was well enough to return to the Ward.

## ANNEX D

### Trust review: recommendations specific to Mrs Keohane's complaint

- Develop a protocol for the care and treatment of people with a learning disability in acute hospitals with reference to Discharge from Hospital. With particular reference to Appendix 5.7, *Guidelines for the acute sector when caring for someone with a learning disability*.
  - Examine admission and discharge procedures in terms of information available to patients and carers prior to admission and on discharge – quality and accessibility of information.
  - Review discharge procedures to ensure that discharge plans are written and available to patients and their carers.
  - For individuals with communication problems a senior member of the team should ensure that the plan and any aftercare or follow-up arrangements are explained to the patient and their carers.
  - Copies of these arrangements should be available on the day of discharge to be given to the patient and their carers and copies sent to the person's GP and local community team for people with a learning disability.
  - If at some stage a review of the care and treatment of a patient with a learning disability is indicated, for example, following a death or complaint, then this should include all the agencies involved.
- The needs of people with specific communication difficulties including people with a learning disability should be incorporated into staff training programmes.

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