The investigation of a complaint by Mrs L against Cardiff County Council

A report by the Public Services Ombudsman for Wales

Case: 201002439

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Introduction

This report is issued under section 16 of the Public Services Ombudsman (Wales) Act 2005 ("the Act").

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

Summary

Mrs L complained to the Ombudsman about the manner in which Cardiff Council handled a referral made to its social services department under Protection of Vulnerable Adults (POVA) arrangements. The referral, which was raised by hospital staff when Mrs L's husband was admitted to the hospital related to concerns about the manner in which he had been allowed to develop the most severe grade of pressure sore. Prior to admission Mr L, who suffered from MS and was bed-ridden was being cared for at home by Mrs L and his carers whilst District Nurses managed his pressure sores. Mrs L was concerned that the POVA arrangements had failed to investigate the concerns expressed and failed to investigate discrepancies in the evidence provided by district nurses at POVA meetings. She was also concerned about the manner in which the Council dealt with her complaint about the matter.

The Ombudsman upheld the complaint finding that the consideration of the referral by the POVA meetings was inadequate and that their findings were unsustainable and should be set aside. He also upheld Mrs L's complaint about the manner in which the Council had considered Mrs L's complaint both in terms of its timeliness and in relation to the substance of its response. The Ombudsman recommended redress to Mrs L in recognition of her time and trouble in pursuing her complaint . He also made a number of further recommendations to the Council; a review to ensure no other service users are at risk; an audit of referrals which accused NHS staff of abuse or neglect to ensure that these have been properly dealt with and; a reconsideration of the original investigation to correct the record and ensure that all relevant lessons have been learned.

The complaint

1. Mrs L complained to me about the way Cardiff Council Social Services Department ("Social Services") handled a POVA[1] referral from nursing staff at the University Hospital of Wales Cardiff which was managed by Cardiff and Vale NHS Trust[2] concerning the manner in which her husband, Mr L, developed pressure wounds. Mrs L complained to Social Services about the handling of the POVA referral and to the Health Board about care provided to MR H by district nurses employed by the Health Board. Following completion of the NHS complaints procedure Mrs L, with the intervention of her legal representative, resolved her complaint against the Trust. It is also understood that there is an ongoing professional body enquiry into the actions of district nursing staff. Accordingly, the complaint Mrs L submitted to me relates to the actions of the Council alone. My investigation did not therefore further consider the actions of the Health Board Staff.

Investigation

2. I obtained comments and copies of relevant documents from Cardiff County Council and I also obtained relevant clinical records and NHS complaint correspondence from the Health Board. I considered these in conjunction with the evidence provided by Mrs L. I have also taken careful account of advice provided by one of my experienced Social Services Advisers, Ruth Forrester BSc MA CQSW DMS MBA, who I consider to be suitably experienced and qualified to advise me on the matters investigated. I have not included every detail investigated in this report but I am satisfied that nothing of significance has been overlooked.

3. Both Mrs L and Cardiff County Council were given the opportunity to see and comment on a draft of this report before the final version was issued. The Health Board was also provided with a copy of a draft of

[1] Protection of Vulnerable Adults

[2] Cardiff and Vale NHS Trust became Cardiff and Vale University Health Board on 1 October 2009. I shall therefore refer to both the former Trust and current Health Board as "the Health Board" in this report

this report to ensure that it is satisfied that the facts contained within this report relating to the actions of its staff are accurate.

Relevant National and Local Guidance and Legislation

4. There have been several relevant sets of guidance issued in relation to POVA procedures in Wales and locally. These include:

- In Safe Hands: Implementing Adult Protection Procedures in Wales: Issued by the Welsh Government in July 2000
- Cardiff City Council Good practice guide to working with vulnerable adults: January 2009
- The Inter-agency procedures for Responding to Alleged Abuse and Inappropriate Care of Vulnerable Adults in South Wales produced by the South Wales Adult Protection Forum (SWAP) . This document was revised in 2004.

5. These documents have been referenced in the Adviser's report which is at Appendix 1. I do not therefore repeat the references to these reports here. I also note that SWAP has subsequently brought out new guidance in November 2010 entitled "Wales Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse". It is noted that whilst this guidance was not in place at the time of the events complained about paragraph 18.1.1 has a bearing on current practice. It states:

> "The vulnerable adult, their relatives and advocates are not normally invited to the first Strategy Meeting since these are professional planning meetings, typically designing an investigation and considering information, some of which may not be able to be disclosed to them. Their presence at this stage may compromise an investigation. However, consideration must be given to how they are informed and how their views and wishes are incorporated into the process. Each case should be considered on its merits and sometimes their involvement may be appropriate at least for some part of the first meeting. If they are going to be invited to Strategy Meetings, careful consideration needs to be given to the management of the meeting and if necessary this may be split into two parts, with and without them. If they are not

invited, consideration must be given to what may be shared with them following the meeting and who is the person responsible for the feedback."

6. In 2005 the Welsh Assembly Government introduced a new complaint handling process for Local Authority Social Services departments. It also issued guidance on this new process entitled "Listening and Learning - A guide to handling complaints and representations in local authority social services in Wales." Paragraph 5.4 of this guidance sets out the Welsh Assembly Government's expectations in terms of "a model of good practice" when there is a complaint about both NHS and Social Services. Paragraph 5.4.4 states that:

> "In most cases, the amended regulations will give local authorities and NHS bodies the job of agreeing who will take the lead. This will include cases where services are provided in a "package" but delivered separately, some by the NHS and some by a local authority. The role of each body will depend on which acts as the 'lead body', as in section 5.3. The lead body must make sure that they keep the complainant informed and, wherever possible, pull together a single joint reply. The body not the lead will simply contribute to the investigation and response. However, nothing in the regulations or guidance removes the duty of care that each body has for the person using the service."

Paragraph 5.2.9 sets out how POVA issues should be dealt with when there are ongoing complaints concerns. It includes **"**There should be no complaints investigation while there is any chance of compromising the [Adult Protection] investigation...this does not rule out aspects of the complaint being pursued at a later date..."

7. The guidance continues in Paragraph 5.2.10, "**...**Where there is a complaint about the handling of an adult protection investigation, this should be raised in the first instance with the relevant adult protection manager. If the complaint cannot be resolved at this level, a formal complaint should be made and should be dealt with in line with the regulations..."

8. Listening and Learning also sets out guidelines for the time it should take to respond to complaints at the different stages of the complaints procedure. Normally it is expected that response at stage one will take 10 working days and a report at stage two should be provided to the complainant within 25 working days. The guidance recognises however, that in exceptional cases this timescale can be extended.

9. On 29 July 2011 the Welsh Government issued a model concerns and complaints policy for adoption by public service providers in Wales which I shall call the "Complaints Wales Guidance". They also issued guidance to public service providers in Wales on the implementation of this policy. The letter issuing the policy and guidance included the statement:

> "It is the view of the Welsh Government that there are profound advantages to the adoption of the Scheme; it will be easier to deal with multi-agency complaints and will provide the service user with a singe contact point and a single investigation process; it places a premium on the importance of early resolution of complaints, where possible avoiding the need to engage the formal complaints process by tackling problems at source; it minimises the number of complaints stages, thus reducing both cost and frustration; and it will facilitate the delivery of joint staff training in partner organisations which can both reduce costs and facilitate more effective joint working."

In terms of complaints involving more than one service provider Complaints Wales states

> "There are occasions when a complaint received will involve more than one organisation. ... Having established the elements of the complaint and which organisations are involved, they should contact their counterpart(s) in the other organisation(s) involved. The complaints officers should then decide which of them should lead on co-ordinating the response to the complainant. It would seem sensible that this should be the organisation with the

greatest involvement in the complaint. However, it may be appropriate for the organisation with the largest complaints handling resource to undertake this role.

The role of the complaints officer allocated to the complaint in question is to co-ordinate the investigations in each of the service areas involved. The ultimate aim, therefore, is to provide the complainant with a single comprehensive "joint" response on behalf of all of the organisations involved. ..."

10. It should also be noted that Public Service Ombudsman (Wales) Act 2005 sets out my jurisdiction and the matters I may investigate. Section 7 of the Act sets out my role to investigate complaint about maladministration in relation to the actions of a public authority or a failure in a service which the local authority is responsible for providing. Section 11 of the Act confirms that I may not question the merits of a decision taken without maladministration by a listed authority in the exercise of a discretion. However, this does not apply if the decision was taken in consequence of the exercise of professional judgement exercisable in connection with the provision of health or social care.

Background to the events complained about

11. Mr L, who was aged 80 at the time of the events in question had had multiple sclerosis for many years and was paralysed from the waist down. He also had an in-dwelling catheter, experienced difficulty in swallowing and was visually impaired. In later years he developed anaemia which needed to be treated with regular blood transfusions which were undertaken in hospital.

12. He was supported at home by Mrs L who was his main carer. In the period leading up to November 2008 she was supported by a carer who was funded through the direct payment scheme operated by Social Services. Supplementary care support at weekends and out of normal working hours was provided by carers from a care service agency (the Agency) . This care package was supplemented by support from a specialist Multiple Sclerosis (MS) Nurse and the district nursing service which visited to change Mr L's catheter every three months. It is generally acknowledged that Mrs L had considerable knowledge and

experience of caring for her husband and was considered to be an "expert carer".

Chronology of the events that led to the complaint

November – December 2008

13. Because of illness Mr L's usual carer was unable to support Mrs L in providing care for Mr L. It appears that Mrs L was mistakenly informed at the time that the direct payments scheme could not be used to pay for an alternative replacement carer for this period. Therefore on **13 November 2008** Mr L was admitted to the Cardiff Royal Infirmary for respite care. Whilst there, he choked on food and developed pneumonia which meant he had to be transferred to the University Hospital of Wales, Cardiff. After his pneumonia was under control, he returned to the Cardiff Royal Infirmary and was subsequently discharged home on 23 December. There is no evidence to indicate that Mr L had pressure sores at this time.

January 2009

14. At the start of the New Year, Mr L developed diarrhoea and his GP was called out to see him. Whilst the diarrhoea improved, it had had a detrimental effect on Mr L's skin and therefore on **9 January 2009** Mrs L contacted his GP about this and the GP arranged for the district nurses to call. A district nurse attended to Mr L's pressure sore on 12 January and the following day he was assessed as having a Grade 2 pressure wound by a district nurse Team Leader (the Team Leader). During this period Mrs L was providing care for Mr L with support from care staff. An analysis of the District Nursing records confirms that district nurses visited approximately every two to three days to change Mr L's dressing in the period up to17 February when the Team Leader visited (her previous visit occurred on 30 January).

February 2009

15. On 17 February the Team Leader recorded that both hips were in a "dreadful condition". The Team Leader made a referral to the Trust specialist wound healing team and the district nurse also submitted a clinical incident form. Thereafter, district nurses attended on a daily basis to dress the wound. On 20 February there was a joint visit to assess Mr L from the Team Leader and a specialist wound healing

nurse. On 24 February, a district nurse assessed one of Mr L's pressure sores as Grade 4. On 25 February, a joint visit involving the Team Leader, the specialist wound healing nurse and Mr L's GP took place. It was agreed that that the GP would arrange for Mr L to be admitted to hospital, on the face of it, to have a blood transfusion for his anaemia although the GP's referral letter also makes clear reference to Mr L's pressure sores.

March 2009

16. Mr L was admitted to the University Hospital of Wales on 2 March whereupon he received a blood transfusion. On 3 March Mr L was assessed by a different (hospital-based) specialist wound healing nurse who assessed three wound sites which were categorised as Grade 3, Grade 3 / 4 and Grade 4. On 3 March the ward manager for the ward admitting Mr L completed a VA1 referral form detailing the extent of his wounds and faxed it to the Health Board's POVA Team. It appears that this referral was forwarded by one of the Health Board's POVA Co-ordinators (the Health Board's POVA Co-ordinator) via fax to the Council's POVA team on 13 March because the VA-1 indicated that Mr L had suffered neglect/abuse whilst in the community. It then appears that because of capacity issues within the POVA Team the referral was passed onto a Lead Manager on 16 March in accordance with the POVA Team's escalation procedures. It then appears that because of her own capacity issues the Lead Manager asked a POVA Co-ordinator within the Social Services' POVA Team who was also responsible for chairing POVA strategy meetings to take the case forward. The referral was therefore allocated to the POVA Co-ordinator on 24 March. The POVA Co-ordinator therefore became responsible for chairing the strategy meeting for Mr L's referral. I shall refer to her as "the POVA Chair" for the remainder of this report. A strategy discussion, dated 25 March, between the POVA Chair and the Health Board's POVA Co-ordinator, records their agreement that a strategy meeting should be convened.

17. A strategy meeting was arranged for 1 April. I have seen that on 26 March Mr L's GP was sent a formal invitation to attend the meeting. However, whilst a number of professionals involved with Mr L did attend the meeting, I have seen that the other professionals appear to have been invited via telephone. I have seen no evidence that Mrs L, the

district nurses involved in Mr L's wound care nor the proprietor of the Agency (the Proprietor) who had been directly involved with Mr L previously and who was responsible for the staff providing Mr L's care were invited to the meeting. I should add that I have been advised that the Proprietor did know of the forthcoming POVA meeting although he has no recollection of being formally invited as he recalled that the issue related to the NHS element of Mr L's care. Mrs L also recalls being informed of the forthcoming POVA meeting following a chance remark by the Proprietor. She subsequently contacted Mr L's Social Worker (the Social Worker) about the meeting. A note made in the record of the strategy discussion on 25 March indicated that the Social Worker would contact Mrs L to inform her of the strategy meeting but emphasising that these meetings were for professionals only. Mrs L confirmed that she did speak to the Social Worker and that he conveyed this information to her.

April 2009

18. On 1 April a strategy meeting was held under POVA arrangements. The meeting was led by the POVA Chair. The meeting was attended by:

- Medical staff who attended to Mr L on the ward
- Nurses who attended to Mr L on the ward (except for the Ward Manager who made the referral who was unable to attend)
- The Team Leader and another district nurse who attended to Mr L's wound at home
- The Social Worker
- The Health Board's POVA Co-ordinator
- A minute taker

19. I shall not reproduce the entire record of the decision making process which was completed on a VA2 form following this meeting. However, given the concern expressed by Mrs L about the information provided at this meeting I refer to relevant entries below.

20. The Team Leader stated that at the end of January, grade 2 sores to Mr L's left hip and buttocks were identified, which were deteriorating

(Note - the Team Leader's entry in the district nursing records on 13 January indicate grade 2 sores at initial assessment).

21. The ward staff confirmed that upon admission, Mr L had one grade 3 wound, one grade 3 / 4 wound and one grade 4 wound.

22. There was significant debate about communication issues and the view was expressed that there could have been clearer and direct communication between the Social Worker, care staff and the district nurses.

23. There was no debate whatsoever recorded in relation to who was responsible for caring for Mr L's wound nor how the wounds were allowed to deteriorate to grades 3/4 and 4.

24. The record of the meeting concluded "It cannot be established who/if someone is responsible for [Mr L's] pressure sore. [Mr L] has received care from his wife, carers (private and agency) and the district nurses."

25. It was also concluded that "Information has been shared, however, no further investigation is required at this time". The outcome of the meeting was "Neglect disproved, however, there are lessons to be learned around communication between all agencies".

26. An action plan was agreed which included the Social Worker providing feedback to Mrs L; training to be provided (by the Health Board's POVA Co-ordinator) into sharing of information and sensitivity and also a discussion about information sharing at team meetings. It was decided that excepting the above, no other action was required.

27. Mrs L subsequently contacted the POVA Chair on 7 April to express her concerns about the outcome of the strategy meeting. In particular it is noted that Mrs L had concerns about aspects of the nursing care provided to Mr L, particularly during the period 13 January to 17 February. Mrs L also expressed concern about the continuity of the care Mr L received during the Team Leader's absence which led the Team Leader to record the "dreadful status of the wounds" upon her

return and to involve the GP and wound team in Mr L's care and to order specialist equipment. The POVA Chair also recorded that Mrs L felt that the District Nursing Team had been negligent by failing to recognise the deterioration in Mr L's wounds. The POVA Chair recorded that she would discuss the matter with the Social Worker and the Health Board's POVA Co-ordinator. It is recorded that following discussion with the latter, the Health Board's POVA Co-ordinator would consult further with the district nurses regarding a time-line and get back to the POVA Chair to determine the way forward. Later on 7 April the POVA Chair was contacted by the Team Leader. It is recorded that the grounds for the decision that neglect had been disproved had been discussed with Mrs L. More information had also been provided by Mrs L, about the period of the Team Leader's absence which in her view led to a lack of continuity of care.

28. On 28 April the POVA Chair made a note of a further telephone call from Mrs L which indicated that she had decided that she intended to complain formally to the NHS. The POVA Chair recorded that she had told Mrs L that she was re-examining the POVA outcome in view of the discrepancies in the information provided by Mrs L and what was said in the first POVA meeting. It is also recorded that the POVA Chair was still awaiting the time-line from the Health Board's POVA Co-ordinator. Later the same day the POVA Chair noted a conversation with the Health Board's POVA Co-ordinator who advised her that a time-line had been received but that it was not as comprehensive as it could have been and that it indicated "some potential for [illegible] to have been done sooner". It was agreed that a meeting would be reconvened for information sharing but it was noted that the Health Board's POVA Co-ordinator would not be available until at least 8 May.

May 2009

29. Sadly Mr L passed away in hospital in the early hours of 14 May.

30. On 14 May the Social Worker contacted the POVA Chair to inform her of Mr L's death. It was agreed that if Mrs L had any concerns about the POVA process, the Social Worker should refer her to the POVA Chair.

31. On 28 May a second POVA meeting was held. The meeting was attended by the POVA Chair, the Health Board's POVA Co-ordinator, the Social Worker, the Team Leader and the specialist wound healing nurse who had assessed Mr L following his admission to the ward. Understandably, Mrs L was unable to attend because Mr L's funeral was to take place the following day. The purpose of the meeting was "to look at the decision-making following the last meeting... and the concerns raised by [Mrs L]." The nature of the allegation was described as neglect[3] with reference to the three pressure sores Mr L developed. The POVA Chair related Mrs L's concerns to the meeting about the care provided to Mr L by the district nurses during the Team Leader's absence. Mrs L was concerned about the different nurses who had visited Mr L at home during this period and their lack of familiarity with his care needs. The POVA Chair also stated that she had requested a timeline to unravel the chronology of events. It is evident this timeline was not provided at any point by the Health Board. The minutes of this meeting record the Health Board's POVA Co-ordinator stating that she had not looked at the "PARIS" records which is how the Health Board records patient information electronically.

32. The Team Leader stated to the meeting that there was a huge deterioration during her absence which had been for "about a week and a day". The POVA Chair pointed out that Mrs L had prepared a clear time-line. The Social Worker commented to the Team Leader that on 13 January Mr L had grade 2 pressure sores and that she (the Team Leader) was back on 26 January. The Team Leader responded by stating she was back on 17 January. (Evidential note: district nursing records confirm the Team Leader visited Mr L on 15, 26 and 30 January. The next entry by the Team Leader which highlighted the "dreadful" state of Mr L's wound was made on 17 February)

33. It was confirmed by the Team Leader that dressings would only be changed if they were soiled. It was also stated that only district nurses looked after Mr L's wound although it was confirmed that early on whilst

[3] In Safe Hands defines neglect as "The failure of any person having the responsibility, charge, care or custody of a vulnerable person to provide that degree of care which a reasonable person in a like position would provide". It further clarifies that this definition includes a "failure to provide medical intervention for the physical and mental health needs of a person."

Mr L was experiencing diarrhoea, Mr L only had simple dressings and Mrs L was more than capable of changing them. The Team Leader said she had not seen Mr L on a daily basis and that she had documented that there was a marked deterioration when she returned from leave.

34. There was also a debate about the grade of wound that needed to be reported and it was felt that there was a lack of clarity in the Health Board's policy since it stated that a grade 3-4 wound should be reported. The Team Leader expressed the view that in which case the referral would have been made sooner but did not believe that it would have changed the outcome.

35. The Team Leader confirmed that she had undertaken two visits with the Wound Nurse and that a discussion had taken place with her wound healing consultant about Mr L's possible admission to hospital. However, Mrs L was reluctant, in view of concerns about his previous hospital care, for Mr L to be admitted.

36. The specialist wound healing nurse's only recorded contribution was to explain that Mr L's haemoglobin was low, he had an urinary tract infection and had a temperature. She is recorded as adding there was "breakdown of the skin which was an organ and that Mr L's organs had started to fail."

37. The POVA Chair concluded "We can only identify there would appear nothing conclusive given [the specialist wound healing nurse's] report on [Mr L's] compromised status, but perhaps opportunities for earlier referral were missed and this could be a reflection on the lack of continuity of [district nurses]". The Health Board's POVA Co-ordinator commented that "lessons learnt" information was disseminated to the whole team.

38. The meeting is recorded as having concluded that details of the alleged perpetrator were unknown adding: "It cannot be established who/if someone is responsible for [Mr L's] pressure sores. [Mr L received care from his wife, carers (private and agency) and the district nurses." It is noted that this conclusion is unchanged from the conclusion arrived at by the first POVA meeting.

39. The meeting stated that the matter had been “Fully investigated” and that the outcome of the allegation was “Neglect, disproved”. It was stated that no further meetings were required and that the POVA process was closed.

Mrs L’s complaint to the NHS

40. On 25 May 2009 Mrs L complained formally to the Health Board. Since Mrs L has not complained to me about the actions of the healthcare staff involved in Mr L’s care, I shall simply refer to the main relevant points arising from Mrs L’s complaint to the Health Board.

41. On 3 August, Mrs L, her Assembly Member, and a representative from her local Community Health Council met with Health Board staff including the Head of District Nursing to discuss her complaint . During the meeting it was recorded that failings in Mr L’s care had already been acknowledged and that training had been put in place and that this would be audited. It was also recorded that the Health Board’s POVA Co-ordinator (who had not been present at the meeting) would provide input to the POVA process which was being led by Social Services (Note: This does not appear to have happened).

42. The Health Board’s Chief Executive wrote to Mrs L on 1 October . Her letter included the following:

> “At the meeting (3 August 2009) you identified a number of shortcomings in relation to the care provided to your husband and staff acknowledged them and offered their unreserved apologies that your husband’s care fell below the expected standards. I know that [the Head of District Nursing] has already acknowledged these failings when she met with you earlier in the year and she has also advised you of the actions she has personally taken to prevent a recurrence...”

43. On 20 October the Head of District Nursing wrote to Mrs L confirming that she and a senior district nurse had met with district nursing staff and that issues including the following had been raised:

- the need to adhere to NMC guidelines in terms of record keeping and documentation.
- a reminder of the national guidance for pressure ulcers and the need for early involvement of clinical nurse specialists and the reporting of pressure damage of grades 3 / 4.
- compliance with a requirement that appropriately trained staff visit at risk or vulnerable patients to ensure a continuity of care.

44. The Assistant Director at the Health Board with responsibility for District Nursing reviewed the actions taken by the Head of District Nursing as a consequence of Mrs L's concerns. The Head of District Nursing subsequently wrote to Mrs L again on 3 December confirming that the Assistant Director had endorsed the actions taken and that the team's practices would be re-audited to ensure that the lessons learnt had had the required effect on staff performance. It was also stated that disciplinary action would be considered if the report of the audit was unsatisfactory. On **2 March 2010** the Health Board's Chief Executive wrote to Mrs L again setting out the actions undertaken and confirming that significant changes had been made to the district nursing service. It was also confirmed that the district nursing service had reviewed its relationship with (presumably the Health Board's) POVA team who now had direct access to the district nursing service's records.

45. It appears that at some point following the Health Board's substantive response of 1 October, Mrs L engaged the services of a solicitor who instigated a claim against the Health Board. The details of the legal actions taken thereafter are not the concern of this investigation; suffice to say that it is understood that the concerns Mrs L raised through the legal process have been resolved. It is also noted, whilst of no relevance to this investigation, that Mrs L's concerns about the actions of the district nurses is subject to a referral to the NMC.

Social Services statutory complaints procedure

46. Following a conversation with the POVA Chair on 28 May 2009, Mrs L, on 23 July, requested the minutes of the POVA strategy meetings. Initially this request for the POVA meeting minutes was rejected under the Freedom of Information Act. However, on 16 September, following the intervention from her Assembly Member and

her Member of Parliament the Council provided Mrs L with copies of redacted minutes of the two strategy meetings. Following discussion with her Assembly Member (AM), Mrs L contacted the Social Services Complaints Officer on 25 November complaining that it appeared from the POVA minutes that the Team Leader had mis-represented information to the strategy meeting. She considered that if the strategy meeting had been in possession of the true facts, they would have reached a different conclusion (or there would have been a different outcome).

47. On 2 December the Complaints Officer discussed Mrs L's concerns with the POVA Chair who had already been in contact with Mrs L. It was agreed that the POVA Chair would meet with Mrs L to discuss her concerns and to obtain further documentation. This meeting was scheduled for 4 December. The Complaints Officer wrote to Mrs L on 2 December 2009 confirming that the POVA Chair had agreed to look at the POVA process again in light of any new information Mrs L had available. She also requested sight of any information Mrs L held in relation to the complaint against the Health Board. I have also seen a copy of an internal e-mail from the POVA Chair to the Complaints Officer setting out Mrs L's concerns and confirming details of their meeting. The POVA Chair also added in the e-mail that she had suggested to her line manager who was the Operational Manager for Adult Services (the Operational Manager) that the case could be reviewed by the Operational Manager herself or a colleague. She felt that this would provide greater impartiality and "certainly I can see from a lessons learnt point of view a failure on my part to corroborate verbal reports from health with a request for documentary evidence such as a timeline. Although I'm uncertain that this would change the outcome given the clinical judgement of the wound team which [Mrs L] does not accept."

48. On 4 December the POVA Chair met with Mrs L. Following this meeting the POVA Chair drafted a letter to Mrs L setting out a summary of the issues they had discussed. The POVA Chair also confirmed that she would liaise with the Complaints Officer and a service manager who at that time had some involvement in POVA matters (the Service Manager) to determine the most appropriate process for reviewing the case. It does not appear that this letter was sent.

49. On 15 December the Complaints Officer spoke with the Service Manager who confirmed that he had discussed the matter with the POVA Chair and that he believed there were questions about the POVA procedures which needed further consideration. He also indicated, given her previous involvement, that the POVA Chair should not be involved in this process. The Service Manager suggested that he himself would look at the whole process and provide a report.

50. On **14 January 2010**, the Complaints Officer met with the Service Manager who had a number of issues of concern including an inability to identify the participants in the first strategy meeting and the fact that the staff who submitted the VA1 had not been present. He also commented that Paragraph 6 of the minutes (of the first strategy meeting) was "unacceptable". The Service Manager made the point that the very fact Mr L arrived at hospital with a grade 4 pressure sore must indicate that there was neglect. He went on to emphasise that this grade of sore does not happen "overnight" – there would have been a "history". The Service Manager also went on to deal with the comment "it cannot be established who/if someone is responsible for [Mr L's] pressure sores". The Service Manager pointed out that consideration was not given to the fact that the clinicians involved in Mr L's care had a clear legal duty towards him. He went on to comment that they should have recognised that there was a risk of pressure sores and taken steps to prevent them and if they developed taken steps to treat them. The Service Manager added that Mr L was not even admitted to hospital because of the sores.

51. The Service Manager also concluded that the minutes of the first strategy meeting did not support some of its conclusions and that the minutes of the second strategy meeting did not support its conclusions in relation to the details of the alleged perpetrator and the outcome of the allegation.

52. The Service Manager was also critical that the first strategy meeting did not establish what happened, did not differentiate between facts and opinion and did not challenge statements made by health staff.

53. The Service Manager concluded that the POVA process needed to answer two questions – did abuse / neglect occur and if it did who was the perpetrator? The Service Manager emphasised that this should be done on the basis of the evidence. It would then make its conclusions based on these facts and using opinion, where needed, to establish whether the actions taken were reasonable.

54. On 20 January the Complaints Officer wrote to Mrs L. It confirmed that she and a colleague had examined the POVA process and the minutes of the strategy meeting and that she had spoken with the POVA Chair and the Operational Manager. I have seen that the content of this letter was approved by the Operational Manager. The Complaints Officer commenced by stating that it was impossible for "us" to make a judgement about whether Health Board staff had misled the POVA strategy meeting and it was suggested that this was a matter for the Health Board to deal with. The Complaints Officer did acknowledge however, that the POVA Chair could have questioned staff from the Health Board more closely about the deterioration in Mr L's skin condition and the steps taken to deal with this. It was also acknowledged that Health Board staff offered opinions on the progress of Mr L's pressure sores but that on reflection the POVA Chair could have asked for further information about this to ensure there was no confusion between fact and opinion. The Complaints Officer said that the Operational Manager would be discussing this with POVA Chairs to ensure that lessons would be learned.

55. Following receipt of this letter Mrs L spoke with the Complaints Officer on 2 February and it is recorded that Mrs L remained dissatisfied – in particular she believed that the Authority could come to a view as to whether Health staff had misled the POVA meeting. On 10 February the Complaints Manager spoke with a member of the Health Board's complaints team suggesting that the Health Board might want to consider joint mediation. A response was received from the Health Board later indicating that they would not wish to participate in joint mediation because the Health Board "could/would" not do what Mrs L was asking for. The Complaints Officer explained that in that case the matter would be progressed to a Stage 2 complaint.

56. On 12 February a stage 2 investigation was commenced. In March an Investigator was appointed who met with Mrs L on 2 April. Following this meeting I saw that Mrs L e-mailed the Investigator. In her e-mail she states "it it has given me a real sense of relief to hear you apologise and say that the 2nd POVA Strategy meeting did not investigate the allegation of neglect properly." I have seen the Investigator acknowledged this reply. On 2 June 2010 the Investigator completed his report. Mrs L's stage 2 complaint report was e-mailed to her on 11 June. Included in the report was the Investigator's view that "the POVA process is primarily intended to ensure that the person is safe and that any lessons which will prevent any further abuse occurring for this or other individuals are learned". The report's conclusions included the following:

> "A] Based on information shared at the strategy meeting by health and social care colleagues involved in [Mr L's] care consideration was given to the appropriateness of the nursing support and made no judgement that this had been responsible for the condition of [Mr L].
>
> B] A judgement about the clinical matters would be part of the Health Service processes which could result form (sic) the information provided as part of the POVA process. A complaint was made to the Health Service in parallel about [Mr L's] care which I believe led to an apology from the Health Service. This is the usual practice in respect of such cases."
>
> C] As stated... there is a clear distinction between matters of protection that are managed via the POVA process and those of clinical governance and disciplinary matters which are dealt with by the employing body. I am confident that the employing body... was present and received information that would enable them to make decisions about the appropriate course of action. ..."

57. The report made two recommendations – one in relation to providing Mrs L with information and a second in relation to reminding colleagues of the need for clarity when issues arise out of POVA meetings in relation to disciplinary and Clinical Governance.

58. The Chief Officer – Adult Services (the Chief Officer) wrote to Mrs L responding to the report. The letter included the following:

> "...I am confident that all in all the POVA process dealt appropriately with the concerns raised by the VA1 made by [the hospital]. I acknowledge [the Complaint Officer's] point that in the initial POVA strategy meeting the questioning of the colleagues present could have been more robust. However, I feel that [the POVA Chair] remedied this in the second strategy meeting."

59. The Chief Officer also stated:

> "[The Investigator] says in his report that there needs to be a clear distinction between the POVA process,... ' and matters of medical governance. Adult Services is unable to make a judgement on questions of medical or nursing expertise."

60. The Chief Officer and the Complaints Officer later met with Mrs L to discuss her concerns. This resulted in a further response from the Chief Officer on 27 August acknowledging, amongst other matters, that there were inconsistencies between what was said at the strategy meeting and the records of the care Mr L received at home.

61. Mrs L remained dissatisfied with the outcome of the stage 2 investigation and on 2 September requested an independent review at stage 3 which the Complaints Officer forwarded to the Independent Complaint Secretariat. The Independent Review Panel met on 13 December 2010 to:

> Review the way in which the complaint had been handled
>
> Review the conclusions and recommendations of the stage 2 investigation
>
> Review the Authority's response to the recommendations of the stage 2 response.

62. The Complaints Officer, the Investigator, the Chief Officer and Mrs L attended the panel hearing. On 22 December the Independent Panel issued its final report. Amongst the findings of the Panel which are relevant to my investigation is the following:

> "In conclusion, the Panel find that the local authority followed the correct process when initiating the POVA meetings. The panel acknowledge that the process is based upon protecting vulnerable adults from future risk. However, the Panel are of the view that there needs to be a clear mechanism in place to ensure that all relevant information is made available within the POVA process to ensure that appropriate decisions can be reached ... ."

63. The Panel made one recommendation namely that the Council seek to put in place a process within the POVA governance procedures that will ensure that all relevant information is available and considered at future POVA meetings.

64. The Panel also provided an additional observation on the complaints process that Mrs L was required to follow in this case because of the view that local authority staff were unqualified to review or comment on concerns about Mr L's healthcare. The Panel expressed the view that it would have been beneficial if the whole of her concerns including the events at the POVA meetings could have been investigated singly with the NHS taking the lead. The Panel pointed out that whilst paragraph 5.4 of "Listening and Learning" provides comment to this effect, it did not have the ability to issue directions to this effect because of regulatory procedures in place at that time. The Panel acknowledged that this meant that Mrs L had to pursue her complaints separately leading to delays and unnecessary frustration, particularly following the loss of her husband.

65. On **4 January 2011**, the Council's Corporate Director (Social) wrote to Mrs L on behalf of the Council confirming the action that the Authority would take in relation to implementing the Panel's recommendation. The Corporate Director also made reference to the Complaint Officer's approach to the Health Board in relation to a joint response. She confirmed that subject to Mrs L's approval, she wished to

share the Panel's findings with the Health Board so that the two organisations can work better together in the future. The Corporate Director also suggested that in view of my involvement in reviewing public sector complaints handling, that anonymised details of Mrs L's complaint be forwarded to me as an example of where a joint system of complaint handling could be beneficial.

66. On 11 February Mrs L forwarded her complaint directly to me.

Mrs L's complaint to me

On 15 March 2011, my Investigator wrote to Mrs L setting out the scope of my investigation into her complaints. It was agreed that the matters that would be considered were as follows:

In relation to the POVA process

- The overall POVA process failed to comply with the principles and accepted procedures set out within "In Safe Hands" and that Social Services did not follow the principles set out within the guidance.
- Mrs L's concern that the first POVA meeting held on 1 April 2009 failed to undertake an adequate investigation into why her husband was allowed to develop pressure sores and that the meeting concluded that "neglect had been disproven".
- Mrs L's exclusion from the first POVA meeting. Mrs L accepted the explanation that it was professionals only and did not question this at the time.
- Mrs L's concern that the POVA Chair did not ask to see the original notes made by Mr L's carers and the district nursing staff which she still held at home. Mrs L considers that if that information had been available it would have contradicted the statements provided by the district nurses who attended the POVA meeting.
- Mrs L also considered that the POVA process took too long and failed to address the issue of neglect.

In relation to complaint handling

- Mrs L considers that the Council took an unreasonable length of time to deal with her concerns and that they failed to manage her complaint in a timely manner

- Mrs L also considers that the complaints processes concentrated excessively on procedure and the process followed by the POVA meetings instead of examining her complaint about how they dealt with the issue of neglect and its "perpetrators".

67. Mrs L was informed at the outset of the investigation that it would be confined to the consideration of the POVA procedures that were followed and not the care provided to Mr L, and that it is not my role to investigate or comment upon any matters relating to personnel or disciplinary issues.

What Mrs L had to say

68. In addition to the matters set out above, Mrs L felt that it was important, for the sake of the future protection of other vulnerable adults, that the POVA process identifies the "perpetrators" of neglect. Mrs L believed that the public should be protected from "qualified but incompetent practitioners, especially in the case of vulnerable adults who are owed a duty of care."

69. Mrs L also considered that the Authority, should ensure that the principles and procedures set out in the "In Safe Hands" guidance should be followed, particularly in relation to investigating fully; making use of all relevant information; establishing facts and identifying perpetrators. Mrs L also considered that the Authority should recognise the significance of written documentation since verbal accounts and memory cannot always be relied upon.

70. Mrs L believed that organisations should respect timescales for dealing with complaints. She said that if organisations wanted the Public to believe that they take complaints seriously then they should not conduct protracted investigations which are seen "to be denying justice to the "victims" by engaging their "opponents"/complainants in a "war of attrition"".

71. Mrs L also fully supported proposals for a joint complaint handling process as envisaged by “Listening and Learning” and endorsed the view of the Corporate Director in this regard. Mrs L also considered that such an approach would demonstrate some consideration for complainants who may be elderly and / or bereaved.

72. Mrs L expressed the view that Social Services need to recognise that “a breach of a duty of care” constitutes negligence. She points out that the NHS implicitly acknowledged “failure to provide safe and effective care” by providing compensation. She believed that there were inconsistent standards of practice between Social Services and the NHS – “NHS pays compensation which implies liability, social services closes the case...”

73. Mrs L also set out a number of specific criticisms of the way the Council handled the POVA concerns and complaint. In brief they included:

- Concerns about standards of casework management and queries as to whether delays had been actively managed
- Failure to deal appropriately with the issues of “neglect” and “perpetrators”.
- A focus on procedures rather than the welfare of vulnerable adults as exemplified by the Panel’s conclusion that the Council followed the correct process – even though the “correct process” did not get to the nub of the problem – identifying the perpetrators and the neglect.
- Inadequate investigation – ignoring Mrs L’s request to consider documentary evidence at the second strategy meeting; exercising poor judgement and failing to demonstrate a coherent rationale for closing the file with insufficient investigation and analysis.

74. Mrs L is also critical that the Council did not uphold the values promoted by “In Safe Hands” in relation to being patient and public centred and transparent. Mrs L felt that she had had “to do all the running” to find out what was happening and she feels that the there is a

lack of accountability in that she has not had reasons for many of the decisions taken.

75. Mrs L also made the point that it was only because of a chance remark by the Proprietor that she even found out about the first POVA strategy meeting and the concerns about neglect. She believes that it was only by chance therefore that the information came to light which led her to pursue her complaint through the various stages of the complaint procedure through to me. She also pointed out that it took considerable effort on her part with support from her AM and MP to even obtain minutes of the POVA meetings. Mrs L made the point that if she had not found out about the POVA meeting and the concerns about the issue of neglect, she would not have pursued her NHS complaint and therefore the individual practitioners concerned would have escaped scrutiny and would not have had their conduct questioned.

The Council's evidence

76. When my investigation was commenced, my investigator asked the Council to comment on the specific concerns raised by Mrs L. I reproduce the relevant sections of the Authority's response below.

> "A] It is not usual practice to invite family members to strategy meetings, although it is important to consider how they are kept informed of the process. In general terms, this is because where there has been an allegation of abuse or neglect it is impossible to know whether it is true or not. Generally, relatives and service users are informed about outcomes after the meeting. As such, we can confirm that [Mrs L] was not invited to the strategy meeting held on 1/4/09. Given her strong views on the matter, [Mrs L] was invited to the second strategy meeting but at that time she felt unable to attend. It had been agreed that the POVA Chair would send [Mrs L] the minutes of the 2nd strategy meeting but due to an oversight this was not done.
>
> B] The information used by the strategy meeting on 1/4/09 was the VA1 and also verbal reports from the colleagues present. [The Health Board's POVA Co-ordinator], from the UHB safeguarding team, had reviewed the District Nursing Team's notes and gave a

verbal report on them to the meeting. (Evidential note – the minutes of the second strategy meeting record the Health Board's POVA Co-ordinator stating that she had not looked at the "PARIS" records).

C] Although this POVA process involved colleagues from health, the alleged incident happened in the community. It therefore fell to Adult Services to investigate and take responsibility for the POVA process. The evidence considered at the meeting was the VA documents and the verbal reports of the colleagues present. Adult Services is not qualified to make judgments on clinical or nursing matters.

D] [The POVA Chair] had seen the records when she met Mrs L (evidential note – the POVA Chair did not meet with Mrs L before the second strategy meeting). [The POVA Chair] reported verbally to the meeting (see minutes) and gave them this information. Adult Services has already acknowledged, in our response to the stage 1 complaint that the matter could have been handled more robustly and colleagues from health questioned more closely.

E] Where a service user's care needs or general health has altered - particularly where there has been deterioration - Adult Services requires the provider to feed this back to the care manager. The care manager (in practice usually the social worker) will then consider whether a reassessment and/or a change to the care plan are needed. Adult Services would like to point out that we would not be involved in commissioning care for any health or nursing needs. From our database, CareFirst, [Mrs L] herself notified [the Social Worker] of the pressure sores on 24/2/09. However, as [Mrs L] explained to [the Complaints Officer] during the course of the complaint investigation, the district nurses team (DNT) told her and the carers not to deal with the pressure areas/sores at all. The DNT assured Mrs L that they were responsible and would attend to these."

77. During the course of this investigation, my Investigator also interviewed the POVA Chair and the Operational Manager.

78. It was confirmed by these officers that since the alleged neglect occurred in a community setting it was appropriate for Social Services to take the lead in the POVA process. However, the POVA Chair confirmed that since the launch of the "Wales Interim Policy" the procedure has changed so that the Health POVA team (known as "Safeguarding") team will manage all referrals involving allegations of abuse/neglect by healthcare professionals regardless of setting. The Operational Manager commented that the situation which arose in Mr L's case, whereby the abuse/neglect involved healthcare staff, was not a frequent occurrence. The POVA Chair confirmed that at the time the POVA referral was received from the Health Board, there was a reduced capacity within the POVA team which was why it was initially passed to a lead manager from outside the team to progress under their escalation procedures.

79. Following a discussion the POVA Chair had held with the Health Board's Co-ordinator it was agreed that it was appropriate to hold a strategy meeting since the threshold of "significant harm" had been met. Whilst not documented, the POVA Chair recalled that there had been a suggestion from Health at this stage (and reiterated later) that the degeneration in Mr L's skin condition was related to his worsening health and his MS in particular.

80. The POVA Chair confirmed that she had no direct contact with Mrs L before the first strategy meeting. Whilst there was no intention to exclude Mrs L, the POVA Chair was of the view that it was not bad practice not to include her in that meeting. The POVA Chair said that her notes confirmed that it had been agreed that the Social Worker would inform Mrs L of the POVA meeting but explain that it was only for professionals to attend. The POVA Chair confirmed that it was usual practice not to include relatives / carers of alleged victims in a first strategy meeting because its purpose was to gather more information in relation to the allegation and determine any investigative route. The Operational Manager was firmly of the view that Mrs L should not have been allowed to attend the first POVA strategy meeting.

81. The POVA Chair confirmed that Mr L's views had not been sought prior to the first POVA strategy meeting, despite there being no issue with his capacity. The POVA Chair also confirmed that Mr L did not have a representative invited to the meeting and that it would not have been the Social Worker's role either. The POVA Chair drew attention to the Wales Interim Policy which looked more closely at attendance in strategy meetings and that as a consequence more thought is now given to the grounds for excluding individuals. Since the POVA Chair had not spoken directly to Mrs L prior to the first strategy meeting, she did not believe that she had been aware of her concerns about the role of the district nurses beforehand.

82. In terms of documentary information for the first strategy meeting, the POVA Chair confirmed that she had requested that the Health Board provide a timeline for the events that led up to Mr L's admission. She confirmed that no such timeline was ever provided and that no clinical records were produced either before, or during, the strategy meetings. It was her normal practice to request such records. She also confirmed that the district nurses who attended the meeting did not have any records with them to refer to. She does not recall Mrs L's offer to provide the District Nursing records held at her home before the first meeting but pointed out there had not been any direct contact between her and Mrs L prior to that meeting. The POVA Chair stated that she did not follow up the failure to provide documentary information but could not recall why. The Operational Manager also felt that there could have been clearer requirements for all those present to bring all relevant information to the POVA meeting to inform the outcome of the meeting. She also felt that the Council could have also attempted to secure reports from those professionals who were unable to attend.

83. The POVA Chair confirmed that she had invited the Team Leader to attend the first meeting since she had been responsible for the district nursing team that had cared for Mr L and would be in a position to provide an overview of the care he received. The POVA Chair had not been aware that the Team Leader had been personally involved in the care provided to Mr L at that point. She also confirmed that the second district nurse who had attended the first strategy meeting had not been

specifically invited to attend. The Operational Manager commented that Social Services do not commission any care related to the dressing of wounds and would not have expected the carers arranged by adult services to have carried out such tasks.

84. The POVA Chair confirmed that whilst she had invited Mr L's GP to the strategy meeting he had failed to respond. She commented that she should have chased him for a response and if he was unable to attend, tried to obtain a report from him on Mr L.

85. The POVA Chair confirmed that she had not invited anyone from the Agency to attend the first strategy meeting and that no reports were requested from them. The POVA Chair confirmed that she should have done so. The carer provided for by direct payments was also not invited. The Operational Manager agreed that there were areas to review such as why the care providers were not invited to attend.

86. The POVA Chair said that the appropriate people had not been present at the first strategy meeting. She also commented that the purpose of the meeting was to look at the allegation, determine any investigation route or to arrive at an outcome. She felt that perhaps they had not had sufficient information to do so and that she had not been challenging enough of the professionals who had attended. The Operational Manager agreed that there might have been a lack of challenge by the POVA Chair of the district nursing staff who had attended the POVA meeting although she suggested that this might have stemmed from the good working relationship they had with the Health Board's POVA Co-ordinator who was seen as being objective and therefore better placed to challenge nursing staff, given her nursing knowledge.

87. The POVA Chair said that in 2009 they did not have the "non-criminal investigation tool" available. However, they now use this tool where a non criminal investigation is required. With hindsight the POVA Chair now considers that the referral should have been investigated.

88. The POVA Chair also accepted that the minutes of the meetings were not very clear and should have better captured the discussions at

the meetings and the rationales for some of the findings that were arrived at. She confirmed that signing off the minutes of the meetings was her responsibility. It was accepted that the discussion that led to the statement "It cannot be determined who / if someone is responsible for [Mr L's] pressure sores" was not documented and confirmed that this statement had been copied directly from the VA1 form. The POVA Chair said that care staff and Mrs L appeared to have been changing dressings. However, pressure/wound care was the responsibility of the district nurses who were attending on a daily basis during the period of concern. The POVA Chair acknowledged that she would have been aware that the district nurses would have been responsible for Mr L's wound care. The POVA Chair confirmed that there was no recognition by the district nurses that attended the meeting of their responsibility in relation to the wound care. The Operational Manager said that in Mr L's case it was evident that the minutes of the POVA meeting had been condensed and were brief and rather inadequate and there was an element in the minutes of opinion being reported as fact. The Operational Manager explained that some of the changes that had been brought about subsequently included setting up a new arrangement of internal auditing, so that the three POVA Chairs challenged one another's practice. Changes had also been introduced in terms of gathering and recording evidence.

89. The POVA Chair confirmed that they had not sent out the minutes of the strategy meetings to Mrs L. These minutes were confidential to all parties attending the meeting. She confirmed that the minutes were shared with Mrs Ls in a redacted form after she made a Freedom of Information request and with the agreement of the health staff, who, according to the Council, had to be consulted regarding their willingness to disclose the minutes.

90. The POVA Chair confirmed that she decided to convene a second strategy meeting after she became aware of Mrs L's concern about the district nurses' care of her husband. Again, she felt that some other professionals should have attended the second meeting or at least that reports should have been obtained from them about Mr L's care. However, they did not attend and she did not request any reports although it was helpful that the wound care nurse was present. At this

point, and as far as the POVA Chair could recall, she was aware that the Team Leader provided direct care to Mr L during the period of concern. The POVA Chair recalled however, that Mrs L had felt that during the period of concern Mr L's care was covered by other district nurses who did not know Mr L well. The POVA Chair confirmed Mrs L was not invited to the second strategy meeting but was to be offered the opportunity to meet at a case conference.

91. The POVA Chair confirmed that she met with Mrs L in December 2009 to explain what had happened and to apologise for her own shortcomings. At the meeting she had agreed to send a letter to Mrs L summarising their discussions and her apology. Whilst she had drafted that letter and a copy was provided to me, she was instructed by the Service Manager, not to send the letter. She understood that this was because Mrs L had, by then, invoked the Social Services complaints procedure.

92. The Operational Manager was concerned that too much was carried out by the NHS outside of the POVA process even though they did have a responsibility to report on the outcome of POVA referrals. In Mr L's case the NHS did not return to POVA Chair with the formal outcome of what they did. The Operational Manager said that as a number of concerns were often being dealt with directly by health the full extent of issues may not always have been reflected in the POVA meeting minutes.

Professional advice

93. My Professional Adviser (the Adviser) has provided me with a report which I have reproduced in its entirety at Appendix 1. I do not intend to dwell on the Adviser's comments here since they will be considered comprehensively in the next section. It should be emphasised however, that it is a matter for me to determine the findings of the report having taken any professional advice into account.

Analysis and conclusions

94. I have taken careful account of the professional advice I have received in order to formulate my findings. Certain elements of this case have been difficult to determine because the actions of individuals

employed by two different public bodies impacted on the way the POVA process was handled. The investigation also needed to bear in mind the fact that Mrs L has resolved her complaint against the Health Board and therefore my comments will have to be confined to the actions of Cardiff Council as the authority responsible for leading the POVA process. That said, the POVA process by its very nature cannot, and should not be compartmentalised and therefore I will be sharing this report with both Cardiff and Vale University Health Board and the relevant Departments of the Welsh Government for them to consider how the processes for dealing with cases concerning vulnerable adults such as Mr L may be improved in the future.

Handling of the POVA process

95. Rather than deal with the issues Mrs L has raised individually I shall refer to them as a whole as there are a number of inter-related and common themes that are relevant to her concerns.

96. The first and most important point I would make here is that the whole purpose of POVA arrangements are to safeguard vulnerable adults. The mere fact that Mr L was allowed to remain in a situation where his pressure sores deteriorated to the extent they did suggests to me that by the time Mr L was admitted to hospital on 2 March 2009 there had been a failure to protect Mr L. Once Mr L was in hospital and being actively treated it appears that his pressure sores were improving, albeit slowly. Since the potential source of neglect had, by then, been addressed, it is my view that it was incumbent upon the POVA process to investigate how this situation had arisen and whether there was a potential risk to other vulnerable adults in the same situation as Mr L.

97. Starting with the initial POVA referral, I note that whilst a strategy discussion took place, during which there was agreement about the need to convene a strategy meeting, there is no evidence that any other enquiries took place, apart from a brief discussion with the Social Worker. There was no debate about who should attend the strategy meeting and there is no evidence that any thought was given to Mrs L's attendance at this meeting. It is evident that a proper enquiry and investigation was not undertaken before the first strategy meeting despite an expectation in the POVA procedures that this should happen.

I do however, take note of the Adviser's comment that this is not usually possible.

98. The strategy discussion took place on 25 March, some 12 days after it appears that the Social Services POVA team received the referral. At the time of the referral it appears that very little information was available about the cause / perpetrator of the neglect and no investigation appears to been undertaken. It is therefore concerning that the first strategy meeting took a further 6 days to convene. Whilst it is appreciated that Mr L was by now in a "safe" environment, it still leaves a total of some 19 days (29 days if you include the initial completion of the referral by the Health Board) during which time (as far as the Council would have been aware) other vulnerable adults may potentially have been subject to the same neglect. I appreciate that at the time the capacity of individual officers within the POVA team appears to have been compromised, however, it was incumbent, in my view, for the Authority to have put effective measures in place which sought to ensure that relevant guidance was followed – in particular given the lack of an early investigation. That it did not do so on this occasion is, in my view, a failing.

99. I turn now to the first strategy meeting. The POVA Chair has already recognised, with hindsight, that the correct individuals were not present at the meeting. The GP did not attend the meeting. Neither the representatives of the carers nor Mrs L were present or indeed invited. Finally it is also noted that Mr L had no representation at the meeting. This contrasted with the fact that individuals who had direct responsibility for the care of the pressure wounds which had led to the referral in the first place were present at, and contributed to, the meeting. I can fully understand why Mrs L felt that this was unfair and I agree, as an impartial observer, that this gives a perception of bias. I am not critical of the decision to exclude Mr or Mrs L from the strategy meeting since the "in safe hands" guidance envisaged that such a meeting was normally for professionals to attend. However it is regrettable that no rationale for doing so was provided, particularly as there was no evidence to justify the exclusion. It is my firm view that the meeting was not attended by the appropriate professionals and this gave the appearance that the appropriate checks and balances were lacking. I

consider that the strategy meeting was fundamentally flawed in its composition.

100. It has also been accepted that not all the relevant information was available at the POVA meeting and that the NHS failed to provide the POVA Chair with the evidence she requested both before, during and after the meeting. I find it extraordinary that a meeting to consider how a patient developed Grade 4 pressure wounds decided to consider whether that patient had suffered neglect from those attending to him without sight of the relevant clinical records. The point has been made that it would not have been the role of the POVA Chair to interpret clinical records. I consider however, the POVA meeting should have been attended by independent healthcare professionals capable of doing so. Furthermore, it is clear to me that information provided during the meeting did not appear to correspond with contemporaneously documented evidence presented in the clinical records. Examples of this include the discrepancies between contemporaneous clinical records and the information provided to the meeting by Team Leader about the dates during which she was absent and the significant deterioration in Mr L's pressure wounds occurred. I consider the failure to consider relevant clinical records to be a significant failing.

101. Having concluded that that the first meeting did not have the appropriate professionals present nor did it have sight of any clinical records, there was still the opportunity for the situation to have been retrieved. Given that there had been no enquiry preceding the first strategy meeting, I, like the Adviser, would have expected the strategy meeting to have commissioned a proper investigation. Again, I agree with the Adviser, that because the issues involved were predominantly clinical, the enquiry should have been carried out by the NHS (using professionals unconnected with the team who cared for Mr L) reporting their findings back directly to the POVA meeting. However, this did not happen and I consider this to be an opportunity missed.

102. What did in fact happen was that the strategy meeting concluded that it could not be established who/if someone was responsible for Mr L's pressure sores, that neglect had been "disproven" and that no further investigation was required. Given that there was no recorded debate

about who was responsible for caring for Mr L's wounds, I cannot understand the basis for the meeting's assertion that it was unable to establish who was responsible for Mr L's pressure sores. My enquiries for example have been able to establish that Social Services were aware that healthcare staff would have been responsible for Mr L's wound care. I can therefore understand why Mrs L questions the objectivity of the meeting given the professionals in attendance. The meeting also concluded that neglect had been "disproven". Again I see nothing in the recorded minutes of the meeting to give any indication that neglect was disproven. The definition of neglect is set out in paragraph 32. I have seen no evidence to persuade me that the issue of neglect was even discussed, let alone disproven. I therefore conclude that the POVA process leading up to and including the first strategy meeting was flawed and its outcome should not be relied upon.

103. The second POVA strategy meeting which was convened, it appears, because of the concerns which Mrs L raised with the POVA Chair about the role of the district nurses, had a slightly different composition to the first. The meeting was attended by the POVA Chair, the Health Board's POVA Co-ordinator, the Social Worker and the Team Leader with the substantive difference being the additional attendance of a specialist wound nurse who had assessed Mr L following his admission to hospital. The GP did not attend (nor present a report) and no representatives of Mr L's carers were invited. Mrs L does not appear to have been invited because of Mr L's recent death and it was agreed that she would be invited to a case conference (which never took place). The main recorded contribution of the clinical nurse specialist appears to relate to comments about Mr L's state of health and his skin integrity, presumably following her assessment since we have seen no evidence that either a timeline or clinical records were available during this second meeting. This was reaffirmed by the Health Board's POVA Co-ordinator who is recorded as not having seen the "PARIS" records.

104. Limited discussion was recorded during the meeting about the quality of care Mr L received between January 2009 and March 2009 the meeting acknowledged that 'perhaps opportunities for earlier referral were missed'. There was also a debate instigated by the Social Worker about district nurse cover and the continuity of care. However, the

findings of the meeting remained unchanged from the first strategy meeting in that it concluded 'It cannot be established who/if someone is responsible for [Mr L's] pressure sores. [Mr L] received care from his wife, carers (both private and agency) and the district nurses'. Whilst some additional input appears to have been made during the second meeting, I agree with the Adviser that it lacked analysis. The meeting concluded in the section on 'details of the alleged perpetrator … unknown. The outcome of the allegation was 'neglect, disproved'. I reiterate the Adviser's concern that the record of the POVA meeting was able to arrive at this finding so categorically without any empirical evidence or investigation. I have to conclude that the second POVA strategy meeting was also flawed and that again, its outcome should not be relied upon.

105. Although there is a record of a telephone conversation between the POVA Coordinator and Mrs L on the day of the Strategy Meeting, Mrs L does not appear to have received a copy of the minutes of the meeting. However, it is clear from the Council's response to the complaint referred to in Paragraph 78 that "it had been agreed that the POVA Chair would send [Mrs L] the minutes of the 2nd strategy meeting but due to an oversight this was not done". I do not consider this to be an oversight since quite clearly Mrs L, with the support of her MP and AM had to go to considerable lengths to obtain a redacted copy of the minutes of the strategy meetings.

106. The other concern highlighted by the Adviser, and which both the POVA Chair and the Operational Manager recognised, was the inadequacy of the notes of the strategy meetings. I share this concern and whilst Mrs L did eventually receive these minutes, their paucity meant that their value in terms of providing her with an explanation of how the meetings arrived at their findings was unhelpful.

107. Therefore, in summary, I consider that the Council failed to conduct the POVA process in relation to the harm suffered by Mr L in accordance with the guidance and spirit of the guidance and that the findings of the two strategy meetings are unsustainable and should be set aside. Accordingly I uphold all aspects of Mrs L's complaint about

the manner in which the Council operated the POVA procedures relating to her husband's pressure wound.

Complaint Handling

108. I should first like to address Mrs L's point that the review of the POVA process, following Mrs L's complaint, was too focussed on procedure and not on the substance of the matter being considered. Procedure is important and quite clearly if a procedure is not followed correctly then it is likely that I would consider that to be maladministration. However, the work of social and health service professionals relied on the use of professional judgement in conjunction with procedure and therefore it is not good enough to simply "tick the boxes" in terms of following the procedure. Decisions taken within any procedure need to be reasonable, well reasoned, fully evidenced and importantly - transparent.

109. I have already dealt with the length of time it took for the Council to deal with the POVA referral earlier in this report. I shall therefore restrict my comments here to the manner in which the Council dealt with the complaint Mrs L made in November 2009 following receipt of the POVA meeting minutes.

110. I have no particular concern about the manner in which the Complaints Officer dealt with the complaint itself and I agree with the Adviser's view about the manner in which contact was maintained with Mrs L. I am surprised however, given the initial willingness of the POVA Chair and the Operational Manager to arrange a further POVA meeting or undertake a serious case review, that the Council elected to continue down the complaints route. It seems to me that the Council should have sought to resolve this issue before it developed further as a formal complaint. Such action is required by paragraphs 5.2.9 and 5.2.10 of "Listening and Learning". Therefore, I believe that an opportunity to resolve Mrs L's concerns without requiring her to follow the various stages of the statutory social services complaints procedure was missed. Furthermore, I am not persuaded that, at this point, the POVA team were in a position to formally conclude that any potential risk had been dealt with by the Health Board.

111. I consider that the Stage 1 complaints process commenced when Mrs L contacted the Complaints Officer on 25 November 2010. I have seen that the Complaints Officer responded formally to Mrs L on 20 January 2010. This response took significantly longer than the 10 working days envisaged. However, I am satisfied that the Complaints Officer and the POVA Chair were in regular contact and had a number of discussions with Mrs L during this period. I have also seen evidence that the Complaints Officer and her colleagues were genuinely trying to find ways to resolve Mrs L's concerns. This included actively considering holding a further POVA meeting or a serious case review. All in all, and setting aside the potential for a further POVA meeting being convened at this stage, in view of the actions being taken, I am not critical of the time it took to respond to Mrs L on this occasion in terms of complaint resolution. Accordingly **I do not uphold** this aspect of the complaint.

112. I have seen that Stage 2 of the complaints procedure commenced on 12 February 2010. However, before progressing to this stage I note that there were efforts on the part of the Complaints Officer to try to engage with the Health Board in order to secure their co-operation in addressing Mrs L's concerns jointly. Such a joint approach would have been in keeping with "best practice" as recommended in "Listening and Learning". The Health Board did not feel able to participate jointly at this stage.

113. The Stage 2 report was issued to Mrs L on 11 June 2010. Again, this took significantly longer than the 25 working days envisaged by "Listening and Learning". I have seen that the Complaints Officer did experience difficulty in identifying a suitable officer to investigate this matter and it appears that the Stage 2 Investigator did have capacity issues in terms of workload as identified by the Adviser in her report. However, in my view it is the responsibility of the Council to respond to complaints in a timely manner and its failure to do so without good reason merits criticism. Accordingly **I uphold** this aspect of Mrs L's complaint.

114. Mrs L also considers that the complaints processes concentrated excessively on procedure and the process followed by the POVA

meeting instead of examining her complaint about how they dealt with the issue of neglect and its “perpetrators”.

115. In this section I consider the manner in which the Council considered the substance of Mrs L’s concerns. The initial letter of response provided by the Complaints Officer appears reasonable to a point. However, whilst there is an acknowledgement that the POVA Chair could have questioned the health professionals who attended the two strategy meetings more closely, there is no acknowledgement or discussion about what impact these shortcomings could have had on the outcomes arrived at by the meeting. This is what would have addressed Mrs L’s concerns. Furthermore, I note that the Complaints Co-ordinator also commented that it was impossible for “us” to make a judgement about whether health professionals had misled the meeting. I disagree. I see no reason why the evidence presented to the strategy meeting could not have been triangulated with the documentary evidence that was available and which should have been presented to the strategy meeting. I fully appreciate that the Complaints Co-ordinator and her colleagues were not in a position to assess the clinical issues discussed at the Panel and clearly within the context of a Social Services complaint process I would not expect them to do so. However, there were acknowledged shortcomings identified in the POVA process which should have raised questions about how reliable the findings of the strategy meetings were. In my view it was not reasonable to let the matter rest there. I see no reason why a further POVA meeting (or serious case review) could not have been held at this point with arrangements being made to secure appropriate independent clinical input into the POVA process.

116. I turn now to the report at the second stage of the complaint process. It concludes that “consideration was given to the appropriateness of the nursing support and made no judgement that this had been responsible for the condition of [Mr L]”. Whilst I see nothing factually incorrect about the statement, I do have concern again that there was no debate about the quality of the information provided to inform the meeting. I am of the view that it was a shortcoming that the strategy meeting failed to make a judgement about the impact of the nursing support on Mr L’s condition. This is a matter which in my view

the POVA process should have examined albeit with input from an independent nursing perspective.

117. I do not agree with the Investigator's conclusion that a judgement about clinical matters should not be part of the POVA process but should form part of the Health Service process stemming from the POVA process. The referral in this case was made by the NHS to the POVA team. It was the role of Social Services to lead on this POVA referral and not to abrogate its responsibilities because Mrs L was contemplating a complaint against the NHS. It is concerning to me that the Investigator considers it usual practice for POVA investigations to be led by Social Services to be taken forward via the NHS complaints procedure with no reporting back of findings to the POVA meeting. The two processes certainly overlap, however, "Listening and Learning" makes it clear that the POVA process has priority in such circumstances. I consider it imperative that any investigation undertaken by the NHS following a POVA meeting should be reported back to those responsible for the POVA process for appropriate scrutiny. The responsibility of individuals participating in POVA meetings is to safeguard both the individual and any other vulnerable adults. I do not consider that by closing the POVA process on the basis of the information it had at that time this obligation was fulfilled. Clinical Governance is certainly relevant in this context, however, the outcome of the POVA process should inform the Clinical Governance process. As the Adviser pointed out, if the POVA process is abandoned, it does leave one organisation without any external checks. In this case I have seen no evidence that the Health Board formally reported the findings of its investigations and action plans to those responsible for the POVA process. In view of the shortcomings I have identified in relation to the substance of the complaint responses provided to Mrs L, **I uphold** her complaint.

118. I would like to draw attention here to the comments the Adviser made in her concluding remarks. She questions whether the existing guidance for staff managing POVA enquiries is adequate. She comments that the guidance in the South Wales Inter-Agency Procedures probably needs to be strengthened in the area of the involvement or exclusion of carers in strategy meetings. I understand that last year the various adult protection forums across Wales

commissioned guidance entitled “Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse”. I accept that this guidance was not available at the time of Mr L’s referral. However, it does go into greater detail about the involvement of vulnerable adults’ representatives in strategy meetings and this is to be welcomed.

119. Finally, I would completely support and endorse the comments made by the Director of Social Services and the Adviser about pursuing a structure that enables the joint handling of complaints with joint responses being provided to complainants. I do not consider that such joint handling needs a statutory basis and I would encourage all health and social care authorities to adopt this approach as good practice in keeping with ‘*Listening and Learning’.* This approach is expanded upon further by the Welsh Government which in its “Complaints Wales” guidance issued earlier this year. This guidance is unequivocal in its support for a joint approach to resolving complaints. In future I would expect, that if this latest guidance were fully implemented, that a situation such as this where a recently bereaved widow need not pursue separate complaints against two public bodies about care provided jointly. Ultimately, this would be greatly assisted by the use of a common complaints process and the current reconsideration of the social services complaints process should take account of the need for compatibility with the recently introduced Health redress arrangements

120. This case has highlighted a number of concerns relevant to both Social and Health care organisations and for that reason I intend to share this report with both Care and Social Services Inspectorate for Wales and Healthcare Inspectorate Wales for their information.

Recommendations

121. In view of the above shortcomings, I make the following recommendations:

a. I recommend that the Council implements the Adviser’s recommendations in Section 8.0 of her report which include:

- The Council, in conjunction with SWAP, review the involvement of users and carers within the POVA process to ensure that the content is compatible with the Mental Capacity Act.
- The Council, in conjunction with SWAP, consider how POVA referrals involving NHS care might be handled more effectively.
- The Council, in conjunction with NHS colleagues, considers a protocol to enable POVA chairs, where appropriate, to have access to independent clinical opinion in cases involving allegations concern NHS care.
- The Council reviews the capacity of the POVA team to ensure that the availability of POVA chairs can meet fluctuations in demand.
- The Council, in conjunction with SWAP, audit a sample of recent Strategy Meetings and Adult Protection Conferences to consider, and, if indicated, progress the issue of GP participation.
- The Council, in conjunction with NHS colleagues, reviews communication between District Nursing Teams and social workers.

b. I recommend that the Council satisfies itself that all appropriate action has been taken to ensure that other vulnerable adults are not at risk. This could be achieved by conducting a further POVA enquiry and or a serious case review as the Council sees fit.

c. I also recommend that the Council undertakes an audit of any other referrals it receives relating to the actions of NHS staff to ensure that any POVA concerns have been fully investigated and scrutinised within the POVA process.

d. Finally, I recommend that the Council apologises to Mrs L for all the failings identified in this report and pays her £500 for her extensive time and trouble in pursuing her complaint.

An Invitation

122. A recurrent feature of this case is the fact that Mrs L was required to follow two complaints procedures when in fact she had concerns

about the actions of healthcare staff, and the manner in which Social Services dealt with those concerns. In view of this case I **invite** both the Council and the Health Board to make strenuous efforts to ensure that complaints involving both health and social care are handled jointly with one lead point of contact in accordance with the Complaints Wales guidance.

123. I am pleased to note that in commenting on the draft of this report Cardiff County Council has agreed to implement these recommendations. The Health Board has also said that new regulations introduced on 1 April 2011 promote the undertaking of a joint investigations. Accordingly it has confirmed to me that where it is acceptable to the complainant the Health Board will always endeavour to adopt such a joint approach.

Peter Tyndall 31 January 2012
Ombudsman

Appendix 1

Professional Advice to the Public Services Ombudsman for Wales

Complainant: Mrs L

This advice has been prepared for the Public Services Ombudsman for Wales.

It has been prepared by Ruth Forrester, Registered Social Worker with the Wales Care Council. The author holds the following qualifications: BSc, MA, CQSW, DMS and MBA and works independently as a social worker in Wales. The author has no connection with the complainant or any of the professionals involved in the case.

The Ombudsman has provided a full range of background material. This has included the initial contacts between Mrs L and the Ombudsman, a file containing information provided by Cardiff City Council, including material about the complaints of Mrs L at Stages 1, 2 and 3; a file containing health care background information has been provided by Cardiff and Vale Health Board. I have also been supplied with local and national policies and procedures.

Following discussion with the Ombudsman's investigator, it was decided to conduct interviews with Mrs L and two officers from Cardiff City Council, the POVA Chair and the Operational Manager. The advice has been revised in the light of these interviews.

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Key events

13/11/2008	Mr Ls admitted to Cardiff Royal Infirmary.
23/12/2008	Mr Ls discharged home
1/1/2009	GP called, diarrhoea
9/1/2009	Mrs L consulted Mr L's GP about pressure sores, district nurses contacted
12/1/2009	District nurses start work caring for sores.
20/2/2009	Wound team involved
2/3/2009	Mr Ls admitted to UHW for transfusion
3/3/2009	Ward makes a POVA referral
1/4/2009	First POVA Strategy Meeting
14/5/2009	Mr L died
28/5/2009	Second POVA Strategy Meeting
12/2/2010	Stage 2 Complaint Process started
2/6/2010	Stage 2 Report completed by the Investigator
13/12/2010	Stage 3 Independent Complaints Panel

Summary of the complaints

Mrs L has made the following complaints against Cardiff City Council:

1	*The overall POVA process failed to comply with the principles and accepted procedures set out within 'In Safe Hands' and that Social Services did not uphold the principles set out within the guidance.*
2	*(She considered) that the first POVA meeting held on 1 April 2009 failed to undertake an adequate investigation into why her husband was allowed to develop pressure sores and that the meeting concluded that neglect had been disproven.*
3	*She was excluded from the first POVA meeting despite asking if she could attend.*
4	*She was concerned that the POVA Chair did not ask to see the original notes made by her husband's carers and district nurses which she still held at home. She considers*

	that if the information had been available it would have disproven the statements provided by the district nurse who attended the POVA meeting.
5	*She also considered that the POVA process took too long and failed to address the issue of neglect.*

1.0 Procedural background

The guidance for practitioners is contained in three key documents:

- In Safe Hands: Implementing Adult Protection Procedures in Wales: July 2000

This is guidance produced for 'the development of local multiagency codes of practices … for the protection of vulnerable adults across Wales.' It is signed by ministers representing the National Assembly for Wales and the Home Office. It provides a framework for local organisations to work in collaboration to attempt to prevent the abuse of vulnerable adults, and ensure that appropriate action is taken when abuse occurs.

- The Inter-agency procedures for Responding to Alleged Abuse and Inappropriate Care of Vulnerable Adults in South Wales.

This document seeks to implement the guidance contained within, *'In safe hands'* it applies to the South Wales Police Area. It '*seeks to support good practice and has been developed with a view to embracing the ethos of the In Safe Hands Guidance*.' This is referred to in the Health Board notes as the "SWAP" procedures and it is referred to as such in the remainder of this report. The version made available was revised in 2004.

- Cardiff City Council Good practice guide to working with vulnerable adults: January 2009

This document was prepared by the Cardiff Area Adult Protection Committee. It is much shorter and less detailed than the SWAP document. Its stated objective of this document is to assist health and social care practitioners 'to promote good practice in working with vulnerable adults… .' The issues of service user involvement and post POVA support are addressed within the document.

It should however be noted that the first two were produced before the Mental Capacity Act 2005.

The SWAP document includes the following statements,

- All partner agencies/organisations must adhere to the following guiding principles [including to] ensure that when the right to an independent lifestyle and choice is at risk, the individual concerned receives appropriate help, including advice, protection and support from relevant agencies, including an independent advocate [p.5]

- The following core principles will always apply in responding to suspicions, allegations or incidents of abuse involving vulnerable adults [including] acknowledging the person's right to self determination and involvement in decision making is promoted to the fullest capacity. … [p.6] (This paragraph then refers to a later section of the procedure that deals more fully with the issue of capacity.)

- A further core principle set out in the document is that vulnerable adults will have the opportunity and right to independent advice and advocacy when they request it . This will also apply to those vulnerable adults who are incapable such a request but are deemed in need of such independent advice and advocacy. [p.7]

The SWAP procedure requires that a referral form, designated VA1, be completed by the practitioner and his or her own line manager. A further form, designated VA2, the record of decision making process and outcomes should be completed by a 'Designated Line Manager'. [p.50].

The procedure also requires the designated lead manager keep their alleged victim (or, by implication their advocate) informed about the progress of the investigation and the outcome (p 68).

The procedure then requires that a strategy discussion and/or a strategy meeting take place [p.69], the two are distinguished as follows.

A **strategy discussion** is indicated when there are two agencies involved and the issues are relatively easy to resolve. It can take place over the telephone or face to face. Although it may be an informal discussion, '*such discussions must be recorded using the VA2, record of Decision making and outcome form*.'

A **strategy meeting** is convened when further inquiries are indicated and a number of organisations are involved. [p.70].

The decision to hold a strategy meeting is made by the [appropriate] lead manager.

The following are identified as among those who according to circumstances should be present at the strategy meeting, [p76]

- Social Services Lead Manager (chair)
- Social Worker or Care Manager
- Person Making the disclosure (if appropriate)
- Other professionals in an advisory capacity (if appropriate)

The strategy discussion

'The initial strategy discussion is probably the most pivotal aspect of the strategic process and is likely to shape the immediate future of any inter-agency response and investigation' [p.69 para 9.58]

The strategy meeting

issues to be addressed by the strategy meeting [p71 &72]

- The capacity and wishes of the vulnerable adult
- How can information/evidence about the alleged abuse be most effectively gathered?
- How should the family, carers, or advocates be involved?
- Are there other potential victims who may have been abused?

Outcome of strategy meeting

The following are listed as possible outcomes that may result from a strategy meeting. [p 77-79]

- In the event of no further action being indicated the reasons for this must be recorded.
- An internal investigation being undertaken either jointly or by the agency in whose domain the disclosure was made.
- The need for an action plan designed to safeguard and / or reduce the risk to the victim or other vulnerable adults may be identified.
- A further strategy meeting or meetings may be convened.
- An Adult Protection Case Conference may be convened.

The circumstances in which a case moves into the case conference phase are not precisely defined. In general terms, it is dependent upon the seriousness and complexity of the situation

2.0 Background

Mr L was aged 80 at the time of these events. He lived with his wife. Mr L had had multiple sclerosis (MS) for many years. He was paralysed from the waist down, and had a catheter. He also had difficulty swallowing. He had developed anaemia and this was treated with blood transfusions. He was also visually impaired.

He was supported at home by his wife. He had a direct payment from Social Services. This was used to pay a private carer with some additional help from an agency. There was some support from the specialist MS Nurse through visits and the District Nursing Service changed his catheter every 3 months.

Mrs L had great knowledge of managing her husband's problems and also expertise in preventing problems. A good example is that she used a Speech and Language Therapist's advice to develop a routine to stop choking during feeding.

3.0 What happened

Mr L had respite care in the Cardiff Royal Infirmary from 13/11/2008 until 23/12/2008. During his stay, he choked and developed pneumonia and had to be transferred to the University Hospital of Wales, Cardiff. Once

this was under control, he was transferred back to the Cardiff Royal Infirmary and was discharged home on 23/12/2008.

On 1/1/2209, Mr L had diarrhoea and a GP was called out to see him. On 9/1/2009, Mrs L spoke to her husband's GP about Mr L's skin and the district nurses were asked by the GP to call to assess his pressure sores. They cared for Mr L between 12/1/2009 and 2/3/2009 when he was admitted to UHW for a blood transfusion.

Following his admission, hospital staff became aware of the seriousness of his pressure sores and associated osteomyelitis and a referral was made to Social Services under the Protection of Vulnerable Adults Procedure by the Ward Manager. A Strategy Discussion took place between the local authority POVA Coordinator and the Health Board's POVA manager. Although it is not recorded, the local authority POVA Coordinator recalls a suggestion from Health at this point that the degeneration in Mr L's skin condition was related to his worsening health and his MS in particular. [4]

A POVA Strategy Meeting was held on 1/4/2009. There was a delay in holding the POVA Strategy Meeting caused by capacity issues within the POVA team. The meeting was chaired by a local authority POVA chair. The meeting was attended by health service staff, including the Team Manager for the District Nursing Service and one of the other district nurses involved in Mr L's wound care. Mr L's social worker also attended the meeting. Mrs L was not present. The private agency was not invited and the police were not present. The GP did not attend despite being invited. The meeting concluded that '*it cannot be established who / if someone is responsible for JH's pressure sores ... JH has received care from his wife, carers (both private and agency) and the district nurses ...neglect disproved, however there are lessons to be learnt between all agencies ..'.* No further action was decided at the Strategy Meeting and JH's social worker was asked to feedback to Mrs L. Mrs L subsequently contacted the Chair of the POVA Strategy Meeting to express her concerns.

[4] From staff interviews

Very sadly Mr L became infected with Clostridium difficile (C diff) whilst an in-patient and died on 14th May 2009.

Because of the concerns of Mrs L, a further POVA meeting was held on 28th May 2009. Mrs L was not able to attend since Mr L's funeral was arranged for the following day. This meeting came to the same conclusions as the first meeting.

Mrs L was not satisfied with the care that her husband had received from the District Nursing Service or the hospitals and raised a number of concerns with the Health Board. She also contacted the Community Health Council and a patient advocate became involved. A meeting was held on 3rd August 2009 to discuss the complaint. Although Social Services were invited, the POVA Coordinator was not able to attend.

The care of Mr L was reviewed by the Health Board's Assistant Nurse Director and on 3rd December 2009, Mrs L received an apology from the Local Health Board 'the *District Nursing service acknowledges that the care provided for you sadly fell short of expected standards .. we unreservedly apologise ..'*. The letter to Mrs L made it clear that the approach which would be taken by the District Nursing Service was based on service improvement through audit and that if services did not improve, '*disciplinary action will be considered'*. Mrs L was not satisfied with this response and was considering making a further referral to the regulatory organisation for nurses, the Nursing and Midwifery Council.

Mrs L contacted Cardiff City Council in January 2010 to raise her concerns about the POVA process. Her particular concerns were that the POVA meetings were misled by the district nurses. There was a Stage 1 response, but Mrs L indicated that she wanted to proceed to Stage 2. The Social Services Complaints Officer, tried to discuss mediation with the Health Board, but the Director of Nursing refused. An operational manager in Social Services agreed to undertake the Stage 2 investigation on 10th March 2010. The report was not completed and sent out to Mrs L until 10th June 2010. The report concluded that there should be a clear distinction '*between matters of protection that are managed via the POVA process and those of clinical governance and disciplinary matters which are dealt with by the employing body.'*[5] The

[5] Stage 2 Report 2/6/2010

report recommended that '*Adult Services and Health colleagues should ensure that the issues arising from this POVA* (referral) *in respect of process and clarity in respect of the role of the POVA process and its relation to Disciplinary and Governance issues are clear.'* [6]

Mrs L was not satisfied with the recommendations of the report and asked that the matter should proceed to a Stage 3 Independent Complaints Panel. The Stage 3 Panel met on 13th December 2010. The Independent Complaints Panel recommended that ' *the local authority seek to put in place a process within the POVA governance procedures that will ensure that all relevant information is available and considered at future POVA meetings'.*

The Panel also observed that Mrs L had to pursue her complaints separately through two complaints processes, health and the local authority '*leading to delays and unnecessary frustration, particularly following the sad loss of her husband for whom she had provided exemplary care '*. [7]The Panel felt that the concerns '*could be investigated singularly, with the NHS body taking the lead'.* [8]

Mrs L was not satisfied with the response from the local authority and subsequently complained to the Ombudsman.

4.0 Analysis of events

Care plan

The care plan agreed between Mr and Mrs L and Social Services was meeting his needs. In particular, the provision of direct payments ensured that Mr L received continuity of care for his everyday needs, augmented by agency staff. It was also helpful that Mr L had support from a specialist MS nurse. Looking at Mr L's needs, it is obvious that Mrs L had an 'expert carer' role and probably a knowledge base that was as great as many professionals. She wanted to care for Mr L at home for as long as possible and to resist the need for hospital admissions, partly because of his vulnerability to infection. The role of

[6] Stage 2 Report 2/6/2010

[7] Stage 3 Independent Complaints Panel

[8] Stage 3 Independent Complaints Panel

the District Nursing Service, in catheter care and subsequently in wound care was crucial in achieving his safe care at home. One issue raised at both POVA meetings was how long Mrs L could have cared for Mr L at home and whether there had been an honest discussion with her about whether his needs were so great that it was no longer possible to care for him at home. This issue was acknowledged at the second POVA meeting together with an admission that the discussion had not taken place.

Admission to hospital in March 2009 and POVA referral

Mr L was admitted to hospital for a blood transfusion, not specifically for the pressure sores, but on admission the pressure sores were identified as serious. A POVA referral was made by the Ward Manager. In considering the original POVA referral, it is very limited in detail or supporting information and it has not been counter signed by a senior nurse. It is also not clear whether or not any specialist advice was sought before the referral was made.

The POVA Coordinator raised a VA2 and held a Strategy Discussion with the Health Service POVA Coordinator. The records indicate that they '*agreed need to convene strategy meeting to investigate any neglect has taken place..'* The record does not indicate whether any enquiry took place apart from a discussion with Mr L's social worker. There was no debate about who should attend the Strategy Meeting. Mrs L was not invited despite the fact that she was Mr L's sole carer and there has never been any suggestion that she was responsible for the alleged neglect.

First POVA Strategy Meeting

There was a delay between the referral being made and the Strategy Meeting taking place. The POVA Coordinator did not start working on the referral until the end of March 2009. I speculate if this reflected issues of capacity in the POVA team.

Mrs L was aware from the Proprietor of the Agency providing care to Mr L about the first POVA meeting but she was not invited. She thinks that he was planning to attend the meeting although she cannot be sure about this.[9] The agency giving Mr L day to day social care was also not

[9] Interview with Mrs L

invited but the District Nursing Service (Team Manager and district nurse both of whom directly cared for Mr L's wound) together with a Health POVA Coordinator, a Senior House Officer a Senior Registrar and a Ward Manager attended although not the Ward Manager who made the original referral. Mr L's social worker also attended. I note that the GP, who had a great knowledge of the situation, did not attend the meeting. At interview, the local authority POVA Coordinator acknowledged that she should have followed this up because of his great knowledge of the situation. In all, 8 people and a minute taker attended the meeting. Although the POVA meeting considered information from hospital and district nursing services, it is clear that a proper enquiry and investigation was not undertaken before the POVA meeting, or as a result of the meeting, although the POVA procedures show that an enquiry should precede the meeting. In practice, this is not usually possible, and I would have expected that the POVA meeting should have commissioned a proper enquiry. Because the issues involved were predominantly clinical, the enquiry should have been carried out by the NHS reporting their findings back into the POVA process.

An investigation was undertaken eventually as a result of the complaint made by Mrs L to the NHS about her husband's care in hospital and at home. At interview, the POVA Coordinator acknowledged that although she had requested it, the Health Board did not provide a timeline and did not provide any clinical records either at the first POVA Strategy Meeting or afterwards.

The POVA meeting also appeared to be lacking in objectivity and balance because the two district nurses were present but not Mrs L (or a representative of Mr L) nor the other care providers from the agency. The other care providers had as much involvement as the district nurses. From her point of view, it must have appeared that her concerns were not being represented but the professionals she thought may have been responsible for her husband's condition were present and the care agency, who might have been able to give a different perspective were excluded.

I did consider whether the approach of the POVA meeting would be different if Mr L had been admitted from a private nursing home with serious pressure sores, and whether those nurses responsible for his day to day care would have been allowed to attend the meeting. I feel

that it would be unlikely that they would have attended the whole meeting and this does illustrate one of the key points of this complaint, the relationship between the POVA procedures and the NHS.

Second POVA Strategy Meeting

There was some change in the attendance at the second meeting, although far fewer practitioners attended. There were only 5 including the Chair. A Clinical Nurse Specialist for wound healing was present but the medical practitioners were not. The care agency was not invited. The GP did not attend either.

There was some useful advice from the Clinical Nurse Specialist about the overall problems of Mr L.

There was some discussion about the quality of care Mr L received between January 2009 and March 2009. It was acknowledged that '*perhaps opportunities for earlier referral were missed'* and there was some questioning by Mr L's social worker about district nurse cover and continuity but the conclusions were the same that '*it cannot be established who/if someone is responsible for JH's pressure sores'.* Although more information was provided, it lacked analysis and a proper investigation did not occur. The meeting concluded in the section on '*details of the alleged perpetrator … unknown. It cannot be established who/if someone is responsible for JH's pressure sores. JH received care from his wife, carers (both private and agency) and the district nurses'.* The outcome of the allegation was '*neglect, disproved'.* A key concern is that the record of the POVA meeting was able to state this finding categorically without any empirical evidence.

Mrs L was not able to attend the second Strategy Meeting. This is held shortly after the death of her husband and the day before his funeral. It is not clear from the records whether it would have been possible to delay the Strategy Meeting so that she could have attended, perhaps with an advocate or a supporter.

Although there is a record of a telephone conversation between the POVA Coordinator and Mrs L on the day of the Strategy Meeting, [10], Mrs

[10] VA2 Entry, Social Services Case Record 28/5/09

L does not appear to have received a copy of the minutes of the meeting.[11]

Response to the health service complaint

Mrs L made a number of complaints following her husband's death about both hospital care and community services. One unfortunate gap in the response of Social Services to Mrs L is the failure of Social Services to attend a meeting called by the Health Board on 3/8/2009. This meeting did apologise to Mrs L.

Social Services Complaints

Mrs L complained to Social Services in November 2009. A Stage 1 response was sent to her on 20th January 2010. I was impressed by the quality of work undertaken by the Social Services Complaints Officer, who liaised well with colleagues in her own department, with the Health Service and with Mrs L. The letter sent to Mrs L did not resolve the situation and one area which does concern me is that the notes of the two POVA meetings were redacted and the names of the people attending from health were removed. Subsequent interviews carried out indicate that the notes of the POVA meeting were 'redacted' by Social Services at the request of Health. I think that the impact on Mrs L must have been to increase her sense of anxiety.

Mrs L was not happy with the Stage 1 response and the complaint proceeded to Stage 2 on 9th February 2010. The social services complaints officer had some difficulty in finding a Complaints Investigator. She also tried to engage the Health Board in mediation [12] but the Health Board refused feeling that they have gone as far as they can with that approach. She struggled to find an investigator and finally the Investigator was appointed at the end of March 2010. He visited quite quickly and Mrs L responded positively to his visit, but the report was not completed until 10th June 2010. The Stage 2 report was thorough and correctly in my view identified the issue of clinical governance or quality assurance as being central to the concerns of Mrs L. The Investigator states that '*there is a clear distinction between matters of protection that are managed under the POVA process and*

[11] Local authority response to the Ombudsman

[12] E mail from the Complaints Officer to the Operational Manager 12/2/2010

those of clinical governance and disciplinary matters which are dealt with by the employing body'. On this basis he felt that '*in this circumstance if there are concerns these should be directed to the UHB' [13].* I am not sure that such easy distinctions can be made between POVA issues and clinical governance, where patients have been allegedly abused or neglected in NHS care. There is also the issue, prominent in this case where the NHS is acting in multiple roles - as service provider and judge of the service provided as well as a key member of the POVA Conference in providing professional advice. If the POVA process is abandoned in such cases, it does leave one organisation without any external checks. It concerns me that the POVA process was not restarted after the health investigation was completed, and there does not appear to have been any communication between Health and the Council's POVA Chair. This appears to be a gap especially as the health investigation would not have taken place if Mrs Ls had not pursued the issue with health.

Stage 3 Hearing and subsequent events

Mrs L was unhappy with the Stage 2 recommendations and with the help of the social services complaints officer moved on to a Stage 3 Hearing. After the hearing, the recommendations were received and a letter was sent by the Director of Social Services [14]confirming that one of the key points of the Stage 3 findings, the requirement for POVA meetings to consider all relevant information were shared with the POVA Coordinators. In addition, the Director said that she wished, with the permission of Mrs L to share the findings of the Panel with Health so that the organisations can work better in the future, and also to consider whether the case could form part of evidence to the Ombudsman about the joint handling of complaints between health and the local authority.

5.0 Good practice

There was good practice shown in this case by Mr L's social worker in maintaining contact with Mrs L and offering her support in the process after her husband's death. The Council's Complaints Co-ordinator also

[13] Stage 2 Report

[14] Letter from the Director of Social Services to Mrs L dated 4th January 2011

maintained good contact with Mrs L and worked hard to resolve the issues within Social Services and with colleagues in the health service.

6.0 Conclusions

Mrs L's concerns about her experience of the POVA process and the related series of complaints about her husband's care in hospital and in the community raise a number of questions about how concerns about alleged poor care are handled through the POVA process. Whilst there was never any suggestion that poor care was attributable to the care by Mrs L, she was excluded from the first POVA meeting. The referral from health was not properly investigated through the POVA process; instead the POVA meeting relied in the first instance on information from members of the team of practitioners about whom Mrs L had some concerns. One crucial person absent from both POVA meetings was the family GP who had been involved for many years and could have contributed crucial information. The POVA Coordinator acknowledged in a subsequent interview that she should have tried to gain more information from the GP. A second crucial person absent from the meeting was the manager of the private care agency, and again the POVA Coordinator acknowledges that he should have been invited to both POVA meetings.

The second POVA meeting was slightly better because a specialist wound nurse was present, but in both meetings there was no analysis of the information to arrive at the conclusions. Although she was allowed to come to the second meeting, she was not able to attend and I am surprised that it was not rearranged to take into account that she had recently lost her husband.

Although there is some evidence that Mr L's social worker maintained contact with her and let her know the outcome of the meetings, communication with her appears to have been quite mixed and she was not sent a copy of the notes until she made a formal request for the minutes.

The standard of recording at the first POVA meeting was poor. The statement '*it cannot be determined who/if someone is responsible for JH's pressure sores'* was not documented and appears to have been copied directly from the referral form. This point was acknowledged by

the POVA Coordinator in her interview with the Ombudsman's Investigator.[15]

Mrs L felt concerned about her husband's treatment in both hospital and community settings and raised complaints against the NHS. As the Stage 3 Panel Hearing already points out, it appears very difficult for Mrs L to have to pursue her concerns through two parallel processes. One action which might have helped to resolve the problems is for the initial or second POVA meeting to instigate a proper investigation. To assist transparency and openness, the review of Mr L's care from January 2009 – March 2009 and in particular the cause of the pressure sores could have been undertaken by a Tissue Viability Nurse outside of the Health Board, perhaps with a Consultant in general medicine and elderly care.

Once Mrs L started the Social Services Complaints Procedure, the response by the Complaints Officer was very good. I do have concerns that the POVA process was not restarted in the light of the investigation by the NHS.

The question of whether the existing guidance for staff is adequate is important in looking at these complaints. The guidance in the South Wales Inter-Agency Procedures probably needs to be strengthened in the area of the involvement or exclusion of carers in strategy meetings. I note also that the Procedures have not been updated since the implementation of the Mental Capacity Act although there is a reference to the forthcoming legislation. [16]

The difficulty of investigating potential abuse and neglect in NHS settings is illustrated by this complaint. The Council's Area Adult Protection Committee needs to consider existing structures for decision making and seeking advice to ensure that there is as much transparency as possible in investigation. The borderland area between clinical governance and POVA arrangements also needs to be explored. I disagree with the comments in the Stage 2 investigation that there is a clear distinction. There are many situations which might arguably fall into both categories and POVA Chairs need more clarity about whether or

[15] From staff interviews

[16] SWAP Procedures p. 134

not to proceed with an investigation or to refer the problem to NHS governance and disciplinary structures.

Finally, I would completely support the comments made by the Stage 3 Hearing and by the Director of Social Services about pursuing a structure where there can be joined up complaints. In this situation, a recently bereaved widow had to negotiate with both a Local Authority and the NHS about what was effectively a jointly delivered care plan and POVA processes. This is already recommended as good practice by '*Listening and Learning'* does recommend that in a case such as this, the complaint is investigated jointly, with one agency taking the lead. In this case, although the Council had responsibilities under POVA arrangements, the lead responsibility should have been taken by the NHS. There is evidence that the Council did try and seek a mediated solution with the NHS, but that the NHS refused.[17]

[17] Notes of Complaints Officer 10/2/2010 – 12/2/2010

7.0 Complaints recommendations

1	*The overall POVA process failed to comply with the principles and accepted procedures set out within 'In Safe Hands' and that Social Services did not uphold the principles set out within the guidance.*
Evidence	The three major sources of guidance for practitioners were considered. This POVA process appears to have failed to engage with Mrs L as the primary carer or to conduct a thorough investigation.
Analysis	It should be noted that guidance to practitioners about the involvement of carers is quite weak and there is no explicit provision for users and carers to either attend Strategy Meetings or to be excluded and the guidance probably needs to be reviewed. Guidance about the need to conduct a proper investigation is stronger.
Conclusion	Partly upheld because of the failure to engage effectively with Mrs L.

2	*(She considered) that the first POVA meeting held on 1April 2009 failed to undertake an adequate investigation into why her husband was allowed to develop pressure sores and that the meeting concluded that neglect had been disproven.*
Evidence	The first POVA meeting held on 1st April 2009 described the condition of Mr L on admission. Although there was some description of the deterioration in Mr L's condition, especially the development of the pressure sores, there was no real analysis of why the pressure sores occurred. Mrs L was excluded from the meeting and the care agency was not invited.
Analysis	The first POVA meeting relied heavily on evidence provided by two district nurses who were providing care and did not seek additional evidence at all. Possibly an independent assessment of the health records might have generated more evidence and would have certainly provided the appearance of greater objectivity.

Conclusion	Upheld because the POVA process did not include an adequate investigation, despite the fact that this was required by the procedures.

3	*Mrs L's exclusion from the first POVA meeting despite asking if she could attend.*
Evidence	Mrs L was excluded from the first Strategy Meeting. The POVA procedures are not very clear about the inclusion of carers and users in POVA meetings.
Analysis	There was never any suggestion of neglect by Mrs L and it should have been possible for her to attend the meeting at the end or meet with the Chair.
Conclusion	Not upheld because of the vagueness of the procedures on carer involvement in Strategy Meetings.

4	*She was concerned that the POVA Chair did not ask to see the original notes made by her husband's carers and district nurses which she still held at home. She considers that if the information had been available it would have disproven the statements provided by the district nurse who attended the POVA meeting.*
Evidence	The clinical notes were not available at either POVA meeting. In both meetings, the POVA Chair relied on information provided by hospital and district nursing colleagues. At the second POVA meeting, assessment was also provided by a clinical nurse specialist in wound care.
Analysis	I would doubt whether the POVA Chair would have the knowledge or skills to assess the work of the district nurses in wound care. A specialist, independent assessment should have been commissioned by the first POVA meeting. I cannot find any reference in the procedures about seeking a second opinion in cases of alleged abuse or neglect in health settings, although this would be the first step taken in cases of child abuse in the same situation.
Conclusion	Partly upheld because the procedural guidance is weak.

5	*She also considered that the POVA process took too long and failed to address the issue of neglect.*
	The initial Strategy Meeting should not held within 48 hours or the reasons for delay should be recorded. The original POVA referral was made on 3/3/2009 and the Strategy Meeting took place on 1/4/2009. This is a delay of 19 days. The second POVA meeting was delayed because of Mr L's death and the recording shows that the POVA Coordinator was actively working to resolve issues with the social worker and other agencies.
Analysis	There was significant delay between the original referral and the initial POVA meeting. There was a problem of the capacity of the POVA team. I do not feel that the delay contributed towards further potential difficulties for Mr L because he was in hospital, but the delay did contribute to the anxiety of Mrs L. The second POVA meeting was delayed by necessary negotiations with colleagues. The sad death of Mr L was the main factor.
Conclusion	Not upheld because I do not consider that the delay in dealing with the first referral was excessive especially considering that Mr L was in hospital.

8.0 Recommendations

1. Cardiff County Council together with colleague bodies in the South Wales Adult Protection Forum review the sections in the Policy and Procedure about user and carer involvement to ensure that the content is compatible with the Mental Capacity Act.
2. Cardiff County Council together with colleague bodies in the South Wales Adult Protection Forum consider how POVA referrals involving NHS care might be handled more effectively. The Forum might consider this issue through scenario setting and generating guidance for practitioners.
3. Cardiff City Council together with NHS colleagues considers a protocol for POVA meetings to enable POVA chairs to have access to a second, independent clinical opinion in cases involving allegations concern NHS care where it is appropriate to do so.
4. Cardiff City Council reviews the capacity of the POVA team to ensure that the availability of POVA chairs can meet peaks and troughs in demand.
5. Cardiff City Council together with colleague bodies in the South Wales Adult Protection Forum audit a sample of recent Strategy Meetings and Adult Protection Conferences to consider the issue of GP attendance and contribution , and depending on the results consider raising the issues with GP practitioner bodies.
6. Cardiff City Council together with colleagues in the NHS reviews communication between District Nursing Teams and social workers to ensure that social workers are updated about key changes in care plans.