

Report

on an investigation into
complaint no 11 001 206 against
Essex County Council

15 May 2013

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Section 30 of the 1974 Local Government Act says that a report should not normally name or identify any person. The people involved in this complaint are referred to by a letter or job role.

This report has been produced following the examination of relevant files and documents and interviews with the complainant and relevant employees of the Council.

The complainant and the Council were given a confidential draft of this report and invited to comment. The comments received were taken into account before the report was finalised.

Key to names used

Mrs H – the complainant

Mr Y – the complainant's son

The Home – the Council-funded residential home where Mr Y was placed

Ms X – the Home's manager

Report summary

Subject

Mrs H complained that the Council did not properly carry out safeguarding procedures in relation to her son, Mr Y, following an injury he sustained in the Home. Mrs H said neither the Council or the Home took appropriate steps following the incident.

Finding

Maladministration causing injustice.

Agreed remedy

The Council has agreed to take the following steps to remedy the injustice caused to Mrs H and Mr Y:

- a. Pay Mrs H £2,500 in recognition of the distress she suffered in not knowing if the cause of Mr Y's injury could have been discovered; and
- b. Pay Mrs H £500 for Mr Y in recognition of the pain and distress he would have felt on the day of his injury.
- c. Offer Mrs H a meeting with the Council's Adult Social Care Manager to reassure her about the Council's current safeguarding practices.

Introduction

1. Mr Y, who is in his 20s, does not communicate verbally and has a significant learning disability and a diagnosis of autism. He displays challenging and sometimes unpredictable behaviour. In November 2008 he sustained a serious injury while living in a Council-funded residential home. There was a Police investigation. However, there was a lack of forensic and other evidence, and the written report the police provided to the Council reached no conclusion as to how the injury was caused.
2. In 2011 his mother, Mrs H, obtained copies of the Council's safeguarding documentation and became concerned that the Council may not have fulfilled its safeguarding obligations. She was concerned about the lack of medical intervention sought when the Home staff discovered Mr Y's injury and was not satisfied that the Council had taken appropriate steps following the injury and subsequent Police investigation. She felt the incident had been covered up by the Council and the Home.
3. Mrs H approached this office on her son's and her family's behalf in April 2011. The Ombudsman was satisfied Mrs H is a suitable person to bring this complaint because of Mr Y's disabilities. Discretion was exercised to investigate the complaint back to November 2008 even though the events had taken place more than 12 months previously. This was because Mrs H did not have all the necessary information until 2011 and because of the potentially significant fault and injustice to Mrs H, her family and Mr Y. The Council asked for the opportunity to address the complaint through its formal complaints procedure and it completed its consideration of the complaint in September 2011. Mrs H was not satisfied with the outcome, so I have investigated the matter.
4. One of my Investigators has spoken to the complainant and considered the information she has provided and the Council's response to her enquiries. She has also received information from the Police about their investigation and medical information from the hospital where Mr Y had his surgery. She has also received clinical advice.

Legal and administrative background

The Ombudsman's role and powers

5. The Ombudsman investigates complaints of 'maladministration' and 'service failure' by councils and certain other public bodies where someone says it has caused them injustice. In this statement, I have used the word fault to refer to these. Where social care is funded by a council, as here, the care provider is treated as carrying out its functions on the council's behalf. If she finds both fault and injustice, she may ask for a remedy. (*Local Government Act 1974, sections 25(7), 26(1) and 26A(1).*)

6. The Ombudsman has the power to decide whether to start, continue or discontinue an investigation. She can consider the way an authority makes its decisions, but it is not her role to comment on them unless they have been taken with fault. (*Local Government Act 1974, sections 24A(6) and 34(3).*)
7. The Ombudsman cannot investigate late complaints unless she decides there are good reasons. Late complaints are when someone takes more than 12 months to complain to the Ombudsman about something a council has done. (*Local Government Act 1974, sections 26B and 34D.*)
8. The Ombudsman cannot investigate action taken by the police in the course of a criminal investigation. (*Local Government Act 1974, schedule 5 paragraph 2*)

The Council's care of vulnerable adults

9. The Council has published the guidelines it follows where concerns are raised about the care of vulnerable adults. *The Southend, Essex and Thurrock Safeguarding Adults Guidelines 2008* (the SET Guidelines) set out the action the Council should take when it receives safeguarding concerns.
10. Chapter 5 of the SET Guidelines details the actions that should be taken when a concern is disclosed and the timeframes within which those actions should be taken.
11. Paragraph 5.3.3 says that in all cases medical attention should be sought where there is a possibility that an injury may have occurred even where there are no visible signs. Paragraph 5.3.4 says that where sexual abuse is suspected, evidence must be preserved. The person must not be allowed to bath.
12. The SET Guidelines say that an initial form for reporting concerns, SET SAF 1, should be completed within two working days of the concern being raised. Where safeguarding concerns have been identified, a risk assessment should be completed within four hours of receipt of the form by social care and this assessment should be ongoing. The SET Guidelines include a form which should be used to complete this risk assessment (SET SAF Risk) and a closure form (SET SAF 4) to record the reasons for the decision.

The Home's Safeguarding Procedures

13. The Home has its own policy in place for safeguarding vulnerable adults (the Policy). The Policy defines physical abuse and details the indicators of abuse. One of the indicators is described as 'Any injury, bleeding or soreness in the genital, rectal area, which could be an indicator of sexual abuse'.
14. The Policy includes comprehensive guidelines about action that should be taken where abuse is suspected, including notifying the Police and the Council. The Policy says, where abuse is suspected, staff should:

- a. call an ambulance or arrange for a doctor to see the person at the earliest opportunity if they feel the person needs urgent medical help (including completing a body map);
- b. call the police if they suspect a crime (the Policy says to call the Police if in doubt);
- c. contact the home manager to inform them of the situation.

Investigation

15. The Council first identified the Home as a suitable placement for Mr Y in 2006. The Home was registered with the Commission for Social Care Inspection (now the Care Quality Commission) as providing 24-hour support to adults with learning disabilities. In August, the Home carried out an assessment for admission to a placement. The assessment identified risks to Mr Y as financial exploitation, lack of road safety awareness, safety when travelling in the house vehicle and needing close supervision when swimming.
16. In November the Council completed a transition profile before Mr Y's move from Children's to Adult's Services. This recommended a placement offering '24 hour intensive staff support with significant periods of 1:1 time... with shared waking night in a residential environment'. The Council also carried out an assessment under the Disabled Persons Act. This identified some risks, but they were around harm to others as a result of Mr Y's behaviour, rather than potential harm to Mr Y. The Council then carried out an assessment of Mr Y's needs under its Adult Social Care eligibility criteria. The assessment identified several areas of risk based on the two previous reports.
17. The Adult Social Care assessment included a section entitled 'Is there reason for concern about the following'. The assessment then went on to list the relevant areas. It recorded Mr Y had unpredictable behaviours and, as a result, was at risk when accessing the community. Under the heading 'Risk' the assessment noted that Mr Y was very vulnerable and 'could be exploited financially, physically, emotionally and sexually'. The assessment said Mr Y would need a support team that would 'work towards minimising these risks'. The Council also completed a 'Summary of Need' which confirmed Mr Y needed a responsive support team due to his limited insight into risk to his safety.
18. Attached to the assessment was a section called 'Information to Service Provider'. This included the statement '[Mr Y] would not be able to protect himself from those wishing to exploit him, therefore [Mr Y's] support team should minimise this potential to occur'.
19. Mr Y moved into the Home on 25 January 2007. The Home completed two 'Behavioural Action Plans' in February and risk management plans in June. The risk management plans related to risks of Mr Y in accessing the community,

access to the kitchen, travelling in the house vehicle and challenging behaviour. The plans were reviewed in May 2008.

20. On the morning of 30 November 2008 staff at the Home noticed Mr Y had sustained an injury to his rectum and brought this to the attention of the Manager, Ms X, over the telephone. The staff gave Mr Y a bath and paracetamol on Ms X's advice. She decided the injury was probably not suspicious from the information the staff gave her, and they made an appointment with a general practitioner for the following morning. The notes from the Home do not record this level of detail, but say the staff noticed blood when they went to give Mr Y a bath:

"...when gone to be given a bath it was seen that he has been bleeding from his bottom causing piles."

21. Mr Y declined as the day went on. Mrs H has provided a forensic pathology report suggesting Mr Y would have been in considerable pain at the time the injury was inflicted. The notes record that although he seemed to be in a good mood following his bath, he 'seem[ed] very tired and didn't eat a lot of lunch'. He became more lethargic and staff found more blood on his clothes. At 18:00 the Home contacted the on-call doctor, who confirmed the approach staff were taking and that Mr Y should attend the appointment the next day with the general practitioner. The staff became concerned at his deterioration, however, and took Mr Y to hospital that evening where Ms X joined him. The doctor who examined Mr Y around midnight raised concerns that he believed serious abuse may have occurred and Mr Y's parents were alerted. The Senior Registrar at the hospital explained that Mr Y would need to undergo further examination the following day, 1 December. This revealed that he had suffered serious internal injuries.
22. The hospital made a telephone referral to the Council expressing concerns about the nature of Mr Y's injury and completed a SET SAF 1 at 03:20. The corresponding risk assessment document was dated 1 December, but did not record the time it was completed. The Council says it received the referral from the hospital at 00:45 and contacted the hospital at 09:40 to obtain information about the injury.
23. The SET SAF 1 form said Mr Y's parents were notified but there had been limited medical investigation because Mr Y was agitated. It included an assessment of the risk at the time. It said the hospital had not confirmed the injury was non-accidental and that Mr Y would be undergoing further examinations to investigate the injury later that day. The form indicated other service users might be at risk if the injury was confirmed as non-accidental.
24. The next day, the Police began investigating the matter. Then on 3 December the Council called an urgent Safeguarding Adults Meeting attended by representatives from the Council, the Home and the Police. The record of the meeting said:
 - a. The Police had visited the Home the day before to make enquiries.

- b. The staff at the Home had given witness statements and the Police did not doubt the Home's explanations.
 - c. The meeting raised concerns that nobody sought immediate medical attention for Mr Y or considered the possibility of abuse. The notes make reference to 'lessons learned'.
25. The action points from the meeting included:
- a. Police investigations would continue;
 - b. the Home would carry out an internal investigation to ensure appropriate safeguards were in place;
 - c. the Council would carry out an assessment of Mr Y's needs for future healthcare and accommodation.
26. On 9 December the Council held another Adult Safeguarding meeting. The notes of that meeting say the Police felt there was 'very little forensic evidence' because the staff had cleaned the bathroom and washed Mr Y's bedding. The notes were comprehensive and focussed on positive outcomes for Mr Y, as well as ensuring proper safeguarding measures were in place. Action points included:
- a. The Council would undertake an unannounced monitoring visit to the Home to assess risk.
 - b. Regular reviews of the remaining residents to ensure their needs were met.
 - c. Ensuring continuing support planning for Mr Y.
27. A week later, the Council carried out an unannounced monitoring visit of the Home. The visit addressed issues such as the staff to service user ratio and protection of vulnerable adults training. The report said the company had clear accountability for investigations.
28. The care of all service users in the Home was reviewed during 15-19 December, including observation of the Home's practices. The Council reviewed the Home's policies and procedures and a quality monitoring inspection took place. The Council contacted the Commission for Social Care Inspection, which did not suggest further actions and decided not to visit the Home until January.
29. The Council held a third meeting on 19 December, by which point the Police had taken statements from all the staff. The notes say that 'mistakes appear to have occurred'. The notes record a discussion about preserving evidence and the Home would now store any bloodstained clothes in a paper or plastic bag.
30. A fourth safeguarding meeting took place in January 2009. The meeting notes show the Police had concerns about staff failing to obtain more urgent medical

attention given the amount of blood present on Mr Y's clothes. They also said the staff on duty did not relay information about the injury to Ms X accurately. The Police view was there was a 'clear need' for training in this area. The action points from this meeting included:

- a. Actions would be taken about safeguarding procedures and managing the risks to service users.
 - b. To ensure that staff were aware of their duties in seeking immediate medical attention.
31. A further meeting took place in February at which the Council said it needed to meet with Police urgently for an update on the investigation.
32. The final meeting, at which the Council decided to close the safeguarding alert, took place on 10 March. The Police had completed their investigations and decided there was inadequate evidence to proceed. The notes say the Council, with the assistance of the Police, had delivered training on safeguarding to the Home and that any further action was to be considered case management. The Council and the Police undertook to write to Mrs H and her husband about the result of the investigation. Three days later, the Council sent Mrs H a report outlining the steps it had taken about the safeguarding concerns.
33. Key points were:
- a. The Council acknowledged that the Home had destroyed forensic evidence and this impacted on the Police investigation.
 - b. The Police and the Council had since delivered training to staff at the Home, including guidance on preserving evidence.
 - c. Mrs H felt that the Council had not involved her in safeguarding meetings. The Council acknowledged that its procedures were not as inclusive at the time of the meetings and had developed since.
 - d. The Council outlined the possible causes of Mr Y's injury that it had discussed at the safeguarding meetings.
 - e. Mrs H had asked the Council to appoint a safeguarding committee to investigate concerns about safeguarding. However, the Council explained the safeguarding meetings were intended for professionals to feed back information about the investigation and consider information.
 - f. The Council said it had not seen evidence of risk to other service users and would therefore take no action against individuals or the Home. The Council reiterated that it had worked with the Home to improve working practice.

- g. The Council apologised for its failings and offered to meet with Mrs H and gave a reassurance that it had delivered continuing training about preserving evidence.

- 34. Mrs H was not interested in meeting with the Council.
- 35. Mrs H says Mr Y was in a lot of pain throughout the day of the injury. She wants the Council to consider funding an en-suite bathroom for him in his current placement, as he enjoys baths. Mr Y has received compensation for his injuries from the Criminal Injuries Compensation Authority.

The clinical advice

- 36. My clinical adviser's view was that it was inappropriate for the Home to assume that haemorrhoids caused Mr Y's injury based on a telephone call. The adviser also said that a simple inspection would have alerted the staff at the Home to a more serious problem. She formed this view because Mr Y's medical records said the injury was visible and was associated with significant bleeding. The clinical adviser also noted Mr Y did not have a history of constipation or rectal bleeding.

The Council's response to my draft report

- 37. The Council fully accepts responsibility for its own faults and for those of the home it commissioned to provide care for Mr Y, but it queries my clinical adviser's view that a simple inspection by medically unqualified staff in the Home would have alerted them to a serious problem. Nevertheless, it recognises the distress and pain caused, reiterates its sincere apologies, and agrees my recommendations. The Council considers the hospital too had a responsibility to protect forensic evidence, and does not consider it followed through action agreed with the Council, to contact the police if a non-accidental injury was established.
- 38. The Council points to the time that has passed since the incident, and improvements which have been made to its safeguarding process for vulnerable people. There is now much greater involvement in the process, including the investigations of vulnerable people by all partner agencies. The safeguarding guidelines have been and are currently being reviewed to ensure they capture all lessons to be learnt from safeguarding issues. There is also a greater understanding of the roles and responsibilities of all involved, which is reflected in the training provided.

Mrs H's response to my draft report

- 39. Mrs H does not believe the Home made an appointment with the general practitioner (see paragraph 21). She believes that the Police were lied to about Mr Y's behaviours, and that this will have influenced the Police investigation.

Conclusion

The Home's actions

40. I am clear the staff at the Home failed to act appropriately when they discovered the injury to Mr Y. The injury was visible, there was significant bleeding and this could evidently have been an indicator of sexual abuse. The Council should have been informed, the Police called and medical help sought immediately. The failure to do so was fault.
41. When the staff discovered the injury, they were sufficiently concerned to call Ms X. But the advice she gave was not in line with the Policy. She should have notified the appropriate bodies, but instead she made a telephone diagnosis of Mr Y's injury. This too was fault. I do not consider whether an appointment was made with the general practitioner is a fundamental issue although I acknowledge this issue has added to Mrs H's lack of trust in the action taken by the Home.
42. The clinical advice I have obtained says that a simple inspection could have easily revealed more. It is likely that immediate medical attention would have identified the bleeding as an injury rather than haemorrhoids. This may have led to staff preserving evidence which would have assisted the Police investigation, but it is impossible to say whether the Police or Council would then have discovered the cause of the injury or the identity of any perpetrator. Mrs H and her family, however, will be left with the distress and uncertainty that something could have been done to bring any perpetrator to justice. I consider the Council should pay Mrs H £2,500 in recognition of the distress she has suffered in not knowing if the cause of Mr Y's injury could have been discovered.
43. Meantime, Mr Y was left until evening without medical help. Although he was given some pain relief, I am satisfied that earlier appropriate medical intervention would have reduced the avoidable pain and distress he will have felt. He has received criminal injuries compensation, but this does not address the injustice caused by the Council's fault. I have considered the remedy proposed by Mrs H, but do not consider structural works to his current placement, which an objective assessment of need have not identified, are appropriate. I have concluded the Council should make Mr Y a payment of £500 in recognition of the pain and distress he would have felt.

The Council's safeguarding actions

44. Under its policy, the Council should have assessed the risk to Mr Y within four hours of receiving the referral. But no risk assessment form was completed and there is no evidence the Council undertook an assessment. This is despite the SET SAF 1 form indicating other service users could be at risk if the injury was shown to have been non-accidental, and is fault. The Council's chronology of events indicates the Police were informed and the Council liaised with them appropriately. Meetings were held at appropriate intervals and are well documented. The Council also carried out training at the Home in response to the

identified failings. But there is no formal record of the decision-making as required by the Council's procedures and while the reason for closing the safeguarding alert is part of the record of the meeting, the Council also does not appear to have completed a closure form. These failings are also fault. However, I do not consider they have resulted in an injustice to Mrs H or Mr Y.

45. I am also concerned at the Council's apparent lack of intervention after the Police investigation. Where a Police investigation takes place the Council may be limited in making its own enquiries but, once the Police ended their involvement, it could have undertaken its own investigation into the actions of the Home. Its failure to do so was fault. I consider, however, that too long has now passed for a worthwhile investigation to be undertaken. I consider any injustice here can be remedied by the Council offering to meet Mrs H to reassure her about the Council's current safeguarding procedures.

The Police investigation

46. I may not investigate the commencement or conduct of a criminal investigation. I consider it is for the Police to ascertain the veracity of evidence put before it and I therefore will not investigate Mrs H's allegation that the Police were lied to.

Agreed remedy

47. The Council has agreed to take the following steps which I consider are appropriate to remedy the injustice Mrs H and Mr Y have suffered:
- a. Pay Mrs H £2,500 in recognition of the distress she suffered in not knowing if the cause of Mr Y's injury could have been discovered; and
 - b. Pay Mrs H £500 for Mr Y in recognition of the pain and distress he would have felt on the day of his injury.
 - c. Offer Mrs H a meeting with the Council's Adult Social Care Manager to reassure her about the Council's current safeguarding practices.