Summary:

The report gives the Council’s response to a formal joint report of the Parliamentary and Health Service Ombudsman and Local Government Ombudsman regarding a complaint from Mr TK in relation the deprivation of liberty of his brother Mr RK.

The report summarises the findings and the outcome of the Ombudsman’s investigation and provides a response from the Council’s Safeguarding team. A copy of the report is attached for the information (Appendix A).

The Ombudsman has found that Mr TK and his brother Mr RK both suffered injustice as a result of the actions of the five bodies concerned. In response to the Ombudsman’s investigation, a detailed action plan has been developed to
ensure that staff are appropriately trained and aware of best practice around the Mental Capacity Act and Deprivation of Liberty Safeguards. A copy of the review is attached as Appendix B and the action plan is attached as Appendix C.

Reasons for Recommendations:

The Council has considered the findings of the Ombudsman in this case and believes that they are accurate. The Council is committed to learning from this case in order to ensure it provides high standards of care.

Recommendations:

That the Council accepts the findings of the report and agrees to undertake the recommended remedies, namely

1. The Council has, as recommended, written to Mr TK to acknowledge and apologise for its part in the failings of the care of Mr RK
2. The Council pays Mr TK £200 in recognition of the injustice found by the Ombudsman
3. The Council conducts a review of practice around the Mental Capacity Act and Deprivation of Liberty Safeguards and shares this with the Local Government Ombudsman and Mr TK
4. The Council develops an action plan to describe learning from the case, to be shared across Adult Social Care departments, with the Local Government Ombudsman and with Mr TK

Background Papers:

Appendix A – Joint report of the Parliamentary and Health Service Ombudsman and the Local Government Ombudsman

Appendix B – Review of Mental Capacity Act and Deprivation of Liberty Safeguards Practice

Appendix C – Action plan

Category of Report: OPEN
If CLOSED add ‘Not for publication because it contains exempt information under Paragraph (insert relevant paragraph number) of Schedule 12A of the Local Government Act 1972 (as amended).’
## Statutory and Council Policy Checklist

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<th>Category</th>
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<th>Cleared by:</th>
</tr>
</thead>
<tbody>
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<td>YES</td>
<td>Paul Jeffries</td>
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<tr>
<td>Legal Implications</td>
<td>YES</td>
<td>Steve Eccleston</td>
</tr>
<tr>
<td>Equality of Opportunity Implications</td>
<td>YES</td>
<td>Adele Robinson</td>
</tr>
<tr>
<td>Tackling Health Inequalities Implications</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Human Rights Implications</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Environmental and Sustainability implications</td>
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### Relevant Cabinet Portfolio Lead

Cllr Ben Curran, Cabinet Member for Finance & Resources

### Relevant Scrutiny Committee

Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee

## Is the item a matter which is reserved for approval by the City Council?

NO

### Press Release

NO
1.0 SUMMARY

1.1 The report gives the Council’s response to a formal joint report of the Parliamentary and Health Service Ombudsman and Local Government Ombudsman regarding a complaint from Mr TK in relation to the deprivation of liberty of his brother Mr RK.

1.2 The report summarises the findings and the outcome of the Ombudsman’s investigation and provides a response from the Council’s Safeguarding team. A copy of the Ombudsman’s report is attached for the information (Appendix A).

The Ombudsman has found that Mr TK and his brother Mr RK both suffered injustice as a result of the actions of the five bodies concerned. In response to the Ombudsman’s investigation, a detailed action plan has been developed to ensure that staff are appropriately trained and aware of best practice around the Mental Capacity Act and Deprivation of Liberty Safeguards. A copy of the review is attached as Appendix B and the action plan is attached as Appendix C.

2.0 WHAT DOES THIS MEAN FOR SHEFFIELD PEOPLE

2.1 The report has implications for two of the outcomes within the Sheffield City Council corporate plan – ‘Standing up for Sheffield’

- Better health and wellbeing
- Tackling poverty and increasing social justice

Action will be taken to ensure high standards of care for the most vulnerable. At the heart of this is the ability of people to make choices about how the care they receive is provided.

2.2 This case involves the care of an elderly man. The Council is committed to providing high quality care for older people as part of its commitment to make Sheffield not just a great place to grow up and live, but also to grow old.

3.0 OUTCOME AND SUSTAINABILITY

3.1 The report has been prepared in response to a joint public report issued by the Parliamentary and Health Service Ombudsman (PHSO) and Local Government Ombudsman (LGO) on February 20th 2014 following his investigation of a complaint against Chesterfield Royal Hospital NHS
Foundation Trust, North Derbyshire Clinical Commissioning Group, Derbyshire County Council, Moss Valley Medical Practice and Sheffield City Council. The Council is committed to learning from complaints and is taking action to ensure its service delivery is of a consistently high standard and that staff receive all necessary training.

3.2 The Council has carried out a review of its practice around the Mental Capacity Act and Deprivation of Liberty Safeguards. It will ensure that there are rigorous programmes and systems in place to train staff and monitor performance.

4.0 MAIN BODY OF THE REPORT

4.1 This report is in response to a joint formal report from the PHSO and LGO. Mr TK contacted the PHSO concerning the location of care provided to his late brother Mr RK, during the last few months of his life in 2009. Mr TK complained that he and his brother’s wishes were not properly taken into account in decisions about where Mr RK lived and received care in 2009. Mr TK says that as a result Mr RK died in care, rather than at home and that this injustice to Mr RK caused Mr TK distress.

Mr RK lived with his brother Mr TK and their cousin. In 2009 Mr RK had become ill with Alzheimer’s Disease and Diabetes and required medical treatment. A number of agencies were involved with the care of Mr RK. These included three bodies in Derbyshire, because Mr RK’s home was on the border between Sheffield and Derbyshire. These bodies were Chesterfield Royal Hospital NHS Foundation Trust, North Derbyshire Clinical Commissioning Group and Derbyshire County Council. The other body cited in the report was Mr RK’s GP surgery the Moss Valley Medical Practice.

The Ombudsman has looked at Mr RK’s care records, spoken to Mr TK’s advocate and taken account of Mr TK’s comments and those of the five bodies investigated. He also took advice from clinical advisors.

The Ombudsman found that Mr TK had made clear his desire for his brother Mr RK to return home and that this was Mr RK’s stated wish. Mr RK was treated in a number of care settings and passed away in a care home in December 2009. The Ombudsman’s finding is that all five bodies were responsible for service failure in not making it possible for Mr RK to return home.

The Ombudsman accepts that all bodies concerned worked hard and in good faith and had genuine concerns about the suitability of Mr RK returning home because of the condition of his home and his capacity to make a decision. The Ombudsman notes Sheffield City’s Council’s comments that it consistently made the case and sought provision for Mr RK to return home. However the Ombudsman found that collectively, the agencies failed to apply the Mental Capacity Act 2005 and the 2009 Deprivation of Liberty Safeguards (DOLS) to assess Mr RK’s best interests and as a result he was deprived of his liberty.
Specifically:

- Hospital staff failed to carry out a formal assessment of Mr RK’s capacity
- No formal assessment was made of Mr RK’s best interests by Hospital or Care Home staff
- A deprivation of liberty assessment completed whilst Mr RK was at April Park Care Home was completed incorrectly
- Staff from all organisations were non-compliant with the Mental Capacity Act and failed to recognise the need to use the Deprivation of Liberty Safeguards

As a result Mr RK suffered the injustice of not going home and Mr TK suffered the injustice at the distress caused by this not being possible. Consequently the Ombudsman upheld Mr TK’s complaint.

Refusing Mr RK’s request to go home without following the Deprivation of Liberty Safeguards process constituted a breach of the European Convention of Human Rights – article 5 (right to liberty) and article 8 (right to family and private life).

4.2 The Council’s Response

Sheffield City Council accepts the findings and recommendations of the Ombudsman.

The Council acknowledges that compliance to the Mental Capacity Act must begin with the relevant assessment of capacity. Assessing capacity should have been routine to any initial assessment, but did not happen in Mr RK’s case.

 Whilst it is primarily the responsibility of the managing authority (in this case, the care home) to identify a deprivation of liberty, it is also the role of any third party to report any concerns they may have that a person is or might be deprived of their liberty. This was incumbent on Sheffield City Council Social Services staff who visited Mr RK and who were aware of his objection and that of his brother to remaining in the care home.

Sheffield City Council was the Deprivation of Liberty Safeguards Supervisory Body in this case. At that time of these events this function was carried out by the Council’s Mental Capacity Act Support Team. The team was never at any time made aware of the circumstances in Mr RK’s case. Had this been the case the matter would have been pursued and the relevant assessments under the deprivation of liberty carried out.

The transfer of care on October 21 2009 to Continuing Health Care funding meant that Sheffield City Council were no longer the decision maker, as defined in 4.6 of the Mental Capacity Act. This hindered
Sheffield City Council’s own plans to facilitate a discharge home.

Sheffield City Council staff strived to plan a package of care to support Mr RK at home. Had they made appropriate use of the Mental Capacity Act and Deprivation of Liberty Safeguards, it would have provided the legal authority for action in Mr RK’s best interests.

The Council has reviewed its policies and performance in the light of this complaint and has summarised the actions it proposes to take in the action plan attached as Appendix C.

This action plan provides detail of measures the Council proposes to take in the following areas:

- Work to embed the practice of carrying out assessments of capacity
- Quality assurance of capacity assessments
- Appropriate training for all relevant staff and managers
- Visits to Care Homes to provide onsite training and support for staff on The Mental Capacity Act and Deprivation of Liberty Safeguards.
- Embed compliance checks in monitoring of Care Homes
- Ensure regular reporting to senior managers on Mental Capacity Act and Deprivation of Liberty Safeguards

4.3 Implications

Finance
In accordance with Section 30 of the Local Government Act 1974, the Council is required to place a Public Notice in a local newspaper and on a website confirming that a report had been issued by the Parliamentary and Health Service Ombudsman and Local Government Ombudsman advising the public where copies of the report were being made available. The cost of the notices was £844 and this has been met from existing Communities budgets in the 2013/14 financial year.

The remedy of £200 recommended by the Ombudsman has been met from existing Communities budgets in the 2013/14 financial year.

Legal
Section 92 Local Government Act 2000 provides that where a local authority considers that a person has been adversely affected by its maladministration it may make payments or provide other benefits to that person. The Ombudsman’s findings and recommendations have been accepted and the Council is therefore able to make the compensation detailed in this report. The Director of Legal and Governance under the Council’s constitution is authorised to approve payment in those circumstances.

The issues referred to in this case are covered by the 2005 Mental
Capacity Act and the 2009 Deprivation of Liberty Safeguards. The council must have regard to these provisions in making its decisions in this case. The implications of them are set out in the body of the report and the discussion.

Equality of opportunity
As a Public Authority, we have legal requirements under Section 149 and 158 of the Equality Act 2010. These are often collectively referred to as the ‘general duties to promote equality’. To help us meet the general equality duties, we also have specific duties, as set out in the Equality Act 2010 (Specific Duties) Regulations 2011.

We have considered our obligations under this Duty in this report and in particular those relating to disabled people and the Council is committed to ensuring that all citizens, particularly those who are most vulnerable, have access to the information and support they need to access services and make decisions about their lives.

Human rights
The Deprivation of Liberty Safeguards are in place to ensure respect for people’s right to liberty as defined in the Human Rights Act 1998. Refusing Mr RK’s request to go home without following the Deprivation of Liberty Safeguards process in the view of the Ombudsman constituted a breach of the European Convention of Human Rights – article 5 (right to liberty) and article 8 (right to respect for family and private life).

Human Resources
The Council will ensure that all relevant staff are trained in the detail and practice of the Mental Capacity Acts and Deprivation of Liberty Safeguards regulations and that practice is regularly monitored.

5.0 ALTERNATIVE OPTIONS CONSIDERED

5.1 The Council could choose to contest the findings of the Ombudsman, as it is recognised that its staff sought provision for Mr RK to return home. However the Council believes the Ombudsman’s findings are accurate and acknowledges its failure to properly implement the relevant legislation and guidance that would have led to a proper assessment of Mr RK’s desire to return home.

5.2 The Council could choose to contest the recommendations of the Ombudsman as it has measures in place to train staff on the relevant legislation and guidance. However the Council recognises the value of reviewing its practice to ensure it is providing a high standard of service to its users.
6.0 REASONS FOR RECOMMENDATIONS

6.1 The Council has considered the findings of the Ombudsman in this case and believes that they are accurate. The Council is committed to learning from this case in order to ensure it provides high standards of care.

7.0 RECOMMENDATIONS

7.1 That the Council accepts the findings of the report and agrees to undertake the recommended remedies, namely

1. The Council has, as recommended, written to Mr TK to acknowledge and apologise for its part in the failings of the care of Mr RK
2. The Council pays Mr TK £200 in recognition of the injustice found by the Ombudsman
3. The Council conducts a review of practice around the Mental Capacity Act and Deprivation of Liberty Safeguards and shares this with the Local Government Ombudsman and Mr TK
4. The Council develops an action plan to describe learning from the case, to be shared across Adult Social Care departments, with the Local Government Ombudsman and with Mr TK

Author: Dave Luck
Job Title: Complaints Manager
Date: 29/05/14